

# **GENDER AND ILLEGAL DRUG USE**

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I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person where due reference is not made. Thus, unless otherwise indicated this thesis is my own work

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## ABSTRACT

The gendered nature of the drug field has been a topic of increasing interest for the last two decades and is gradually becoming a subject for serious investigation. This thesis addresses the social construction of gender in drug theories, in the epidemiology of drug use, and by exploring a variety of ways that women who use illegal drugs acquiesce and resist gender domination and constitute themselves in the illegal drug worlds.

I begin by examining theories of drug use and dependency. I argue that the gender relations of the wider society are mirrored in the scientific discourses and in the social worlds of users of illegal drugs, and that a gendered analysis improves knowledge and treatment for women and "subordinated males".

Second, I consider questions about the epidemiology of illegal drugs, that is, ways of monitoring the incidence, prevalence and character of illegal drug use over time. The hidden nature of illegal drug use creates obstacles to such monitoring. Researchers in North America and the United Kingdom addressed the measurement difficulties by using a number of indicators to estimate the incidence and prevalence of illegal drug use. In Australia, this method was first attempted in the late 1980s with a pilot project, ACT Drug Indicators Project. Drug indicator data sets (both overseas and Australia) identify predominantly male "subjects" and although the data are now generally broken down by sex, there has been no attempt to examine the best methods of monitoring women's illegal drug use. I examine the ACT Drug Indicators data and its adequacy as a means of monitoring both men's and women's illegal drug use. I argue that the social construction of the data sources, in this case the gendered nature of the criminal justice system, is a relevant factor in assessing the data sources that are used as measures of drug use in the wider community.

Finally, in interviews with treatment workers and women illegal drug users, I examine the process of beginning drug use and identify issues that are still neglected in most drug research. Semi-structured interviews with 51 women who had used or who were using illegal drugs showed that shame arising from sexual abuse and stigma were elements in both informal and formal drug recovery for the majority of the women. While crime is highly correlated with men's illegal drug use, this is not so for women. The interview study shows the variety of ways women deal with the constraining forces of the social construction of gender - both acquiescing and resisting - in constructing an identity that encompasses, for themselves, acceptable illegal drug use and acceptable femininity.

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## CHAPTER 1: INTRODUCTION

Prior to the 1970s, women were virtually invisible in the study of alcohol and illegal drug use. When women were the subject of drug research, it was often in relation to their abnormal sexuality (frigid or promiscuous) or to their role as mothers or potential mothers. That is, women were more interesting for their significance to others than they were in themselves. Factors which may have contributed to the neglect of women in the drug field were the higher rates of alcoholism<sup>1</sup> among men, the under representation of women in the population attending treatment services, and possibly the lack of any special interest in women's problems on the part of most male researchers (Wilsnack and Beckman 1984). In the United States of America, during most of the 20th century, the ratio of male to female alcoholics has been estimated as 5-6 males for each female (Jellinek 1947; Fillmore 1984). The ratios for alcohol dependence symptoms in the latter half of the 20th century have been calculated to be approximately 3-4 males for each female (Vannicelli 1984).

In Australia, a similar situation has prevailed. Data on deaths from cirrhosis of the liver between 1911 and 1987 (a principal indication of alcoholism in a community (English, Holman et al. 1995:169)) show 2-3 males for every female alcoholic (calculated from Drew (1982)). Estimates on high risk alcohol consumption show that men are 3.2 to 3.7 times more likely than women to consume alcohol at levels of high risk (Copeland and Hall 1995).

Estimating the ratios of male to female illegal drug users is more difficult because of the lack of reliable and representative data sources. Levels of illegal drug use and the characteristics of illegal drug users are notoriously difficult to measure given the illegal and sensitive nature of the activity. A solution, used first in North America and the United Kingdom, has been to assemble multiple indicators (such as health and law enforcement data, drug surveys, key informant surveys) to provide the best estimate of trends in drug use. In Australia, attempts to measure the levels of illegal drug use began in the latter half of the 1980s (Mugford 1989), and were modelled on the multiple indicators methods used overseas (Wardlaw 1989; Hando, O'Brien et al. 1997). Information on sex ratios is patchy, but it is sufficient to note at this point that although the ratios vary with age group, ethnicity, time, place and type of drug, most data sources indicate that illegal drug use has been more common among men than women (Ferrence and Whitehead 1980; Ettorre 1992; Copeland, Hall et al. 1993; Jones 1993; Lex 1994; 1995: 16; Hughes, Day et al. 1997).

One reason for the gender difference seems to be related to the legal status of a drug rather than its pharmacological properties (Colten and Marsh 1984). The history of opioid use demonstrates the point. In the last century, in Australia and elsewhere, opioid based patent medications were commonly used and women appear to have been the main consumers (McCoy 1991:8; Kandall 1996). From the turn of the century there were a number of new laws restricting the use of opioids (Berridge 1989; Manderson 1993), and by the middle of this century, most consumers of opioids were men (Lennane 1987).

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<sup>1</sup> The terms 'alcoholic', 'alcoholism', 'addict' and 'addiction' are used when the author of the quoted work has used that terminology.

The small proportion of women with drug problems created difficulties for research. The number of women in a research sample, whether in treatment populations (Lennane 1987) or in general household surveys, was often too small to generate results that provided sufficient power for statistical analyses. For these reasons, in the second national US survey on alcoholism by the Social Research Group, the researchers confined their data collection to men only (Fillmore 1984). Jellinek's historic 1946 study of alcoholism excluded females from the analysis because the number of females was small and the 'data differed so greatly for the two sexes that merging was inadvisable' (1946:15). Thus, women were excluded from the analysis, and from the samples. In other cases the data for males and females were combined making it impossible to detect any distinctive patterns among the women in the sample. In studies of drinking problems among adolescents, most researchers did not differentiate between males and females in their data analysis (Thompson and Wilsnack 1984).

In the study of illicit drugs, the exclusion of women was not generally explicit. Ethnographic studies of illegal drug users began in a serious way in the 1960s. These studies, principally of lower class heroin users in the ghettos of the US cities, do not state that they are studying males exclusively, but this tends to be taken for granted. In a classic early study in the slums of New York City, Preble and Casey (1969) noted the ethnic groups represented among their 150 informants (Irish, Italian, Negro and Puerto Rican), but they make no mention of the sex distribution of the sample. From the text, however, it is clear that the drug users are overwhelmingly males. There is no mention of female activities, in crime or in 'hustling'. The crimes alluded to include burglary, robbery and assaults but there is no mention of prostitution. The place of male street gangs and the tough con-man in the history and distribution of heroin networks is part of the story. In their conclusion, Preble and Casey compare the heroin user to a *working man* (my emphasis) coming home at the end of the day – 'he's worked hard, but he knows he has done something' (1969:21). In these early street studies, the word 'he' is unmistakably masculine and the female heroin user is invisible. Reviewing the ethnographies of heroin users in the US to the 1970s, Rosenbaum notes that women 'are either omitted or seen as peripheral members of predominantly male worlds' (1981:13).

By the 1970s, it was clear that these practices had resulted in a situation where little was known about women's drug use, and concern began to develop. partly as a result of the rise in the women's movement which focussed attention on women's issues in general (Kalant 1980; Wilsnack and Beckman 1984; Murphy and Rosenbaum 1987). In 1975, an interdisciplinary group of researchers at the Addiction Research Foundation in Canada acknowledged that the area of alcohol and drug abuse among women was a 'nonfield', with few recognised experts and virtually no specialised literature (Kalant 1980). The move to redress the balance began at this period, and by 1982 the number of studies of alcoholic women or problem drinkers had more than doubled from the 12 studies reported between 1929 and 1970 (Wilsnack and Beckman 1984: x).

Although there has been an increase in research on women's drug use since the 1970s, most studies have still tended to address the issues raised in the previous research on men. As Johnson notes about alcohol research,

the path that researchers took in their quest for data in the 1970s and the early 1980s was actually a well-worn path defined in earlier times. A vast amount of information began to be published concerning women's drinking and drinking problems, but the research agendas had actually been set in the 1930s, 1940s and 1950s, and, therefore, they arose 'from a social milieu in which gender relations of power went unquestioned' (Johnson 1991:33).

Similarly, research on women's use of illegal drugs began to burgeon in the 1980s. For example, the relationship between drug use history and crime became the subject of study for women as well as men (Inciardi, Pottieger et al. 1982; Pettitway 1987). However, this early research generally applied the theories and models used previously in describing the relationship between men's drug history and criminal behaviour to explain women's experiences in an illegal drug world dominated by men. Feminist research in other fields has shown that simply adding women into the analysis is but the first step in widening research to include women (Smith 1974; Harding 1987). The relationship between problematic illegal drug use and crime is reasonably strong for men but is much less important for women. And according to criminology statistics, the crimes women commit are, on the whole, quite different from those committed by men. Some notion of these differences is evident in the large differences in arrest and imprisonment rates<sup>2</sup> for men and women, with women constituting about 5 per cent of the prison population in Australia and internationally (Biles 1984; Mukherjee and Dagger 1990; Hampton 1993). The causes for these differences are, however, not simple. They arise from a complex interaction of gender both within the criminal justice system and with the wider society.

Cultural values about the gender division of labour have also shaped drug research. As mentioned above, early research focused on men's lives in the drug economy - as users and sellers (Sutter 1966; Preble and Casey 1969; Agar 1973; Waldorf 1973) - with comparisons being made between men in the licit and illicit work worlds. Women generally did not feature in this type of research until the 1990s when women's place in the drug markets became a subject for investigation (Fagen 1994; Mieczkowski 1994; Maher and Daly 1996; Sommers, Baskin et al. 1996).

For women, early research on problematic drug use focused on the woman's supposed poor adjustment to and acceptance of her femininity, with women's problems being seen as more difficult to treat (due to greater psychiatric morbidity than men) and often related to 'female disorders' (Lisansky 1957; Lindbeck 1972; Stevens 1991); such as to menopause and depression (Lolli 1949), sexual dysfunction; such as promiscuity and frigidity (Levine 1955; Karpman 1956; Wilsnack 1984) and personality disorders (Hewitt 1943). Early research drew attention to the greater stigma suffered by women for the same level of drug use as men, and some researchers suggested that the greater level of stigma could have been one cause for the higher level of psychopathology reported among chemically dependent women (Lisansky 1957; Colten and Marsh 1984). Another large body of drug research on women was concerned with the public health threats arising from drug use during pregnancy and mothering. A theme underlying most of this work was that women's dysfunctionality was measured principally in relation to their ability to serve as sexual partners and mothers.

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<sup>2</sup> Although, there has been a trend to greater female imprisonment over the last decade, women still constitute only about a one-twentieth of the prison population (Hampton 1993:4).

The late 1980s, however, saw the development of a woman-centred approach which added new perspectives to drug research (Reed 1985; Reed 1987). For example, abuse, particularly childhood sexual abuse began to be recognised as a common antecedent in the histories of women with drug problems and it became clear that such issues needed to be addressed for those recovering from chemical dependency, and were particularly important in lowering women's rate of relapse (Young 1990). Thus, the research agenda, previously dominated by male perspectives, began to change. There is some evidence, furthermore, that the changing agenda for research on women has since affected research on men. For example, when the issue of sexual abuse was applied to males, it became evident that some drug dependent men, particularly those who have been homeless, have been victims of physical and sexual abuse - an issue not previously identified (Rohsenow, Corbett et al. 1988; Howard 1992; Bammer 1993; Howard 1993; Sibthorpe, Drinkwater et al. 1995).

In Australia the story is very similar, although drug research in Australia began later than in the UK or North America. Research into drug use and treatment in Australia was quite limited until the late 1980s when the advent of HIV/AIDS funding and the National Campaign against Drug Abuse (NCADA) provided resources which have led to in a substantial change.<sup>3</sup> Early Australian drug research drew on the framework of international studies of the period. Thus, research such as that conducted by Reynolds (1976) used treatment populations of both men and women but the topics and variables for analysis were shaped by previously developed international research agendas. Following the overseas trend, women became an explicit topic of research in Australia in the late 1980s. Most of the initial Australian research on women was conducted among populations accessed through institutions particularly prisons (Miner and Angela Gorta 1987) and drug treatment agencies. For example, Waldby (1988) studied mothering and addiction among women in methadone programs and Copeland and Hall (1992) compared women attending specialist women's detoxification residential programs with women in mixed sex treatment services, providing findings generalisable for women in drug treatment programs.

In the late 1970s and early 1980s, researchers noted that there were some people who used illegal drugs only infrequently, for example, experimenters, recreational and situational users (Australian Royal Commission into Drugs 1980; Davies 1986) but there was little research documenting the experiences of these dabblers in illegal drugs. Studies of 'recreational' users, both men and women, funded by NCADA or AIDS funds followed in the late 1980s (Dance 1989; Pilkinton and Mugford 1989; Moore 1993) and drew attention to the pleasurable aspect of drug use (Mugford and Cohen 1989), a point generally ignored in studies of people accessed via institutional sources.

Thus by the 1990s, in Australia and elsewhere, drug research was moving to provide a more gender-balanced picture of drug use which included both male and female perspectives. The widening perspective did not lead automatically, however, to the loss of male bias in doing research. Alcohol treatment studies demonstrate some of the

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<sup>3</sup> The National Campaign Against Drug Abuse was set up as a federally funded national program in 1985. After an evaluation of the program in 1991, it was reconstituted as the National Drug Strategy (Wares 1994; Bowler 1994). For the sake of simplicity, I will use the term National Campaign against Drug Abuse when referring to the program over the decade of its life but use the term National Drug Strategy when referring to specific aspects of the program after its reconstitution in the early 1990s.



complexities of the change. In a classic meta-analysis of alcohol treatment outcome studies between 1972 and 1980, Vannicelli (1984) had noted that the majority of the studies had been conducted with men, and that women comprised only 7.8 per cent of the 64,654 subjects. In a reassessment of the literature for 'addiction journal articles' published during 1990, Brett, Graham and Smythe (1995) found that although 'the proportion of females represented in addictions research' had increased compared with earlier periods, studies using only male subjects were still common, with female subjects comprising about a third of those studied. In addition, problems of representativeness and generalisability remained. While the research on females was 'more likely to describe findings as being restricted to females', that 'conducted on male samples was often described as if male experience was generalizable to both males and females' (Brett, Graham and Smythe 1995:32). Similarly, a review of gender issues in the treatment of nicotine, alcohol and illegal psychoactive drugs found that while women had now become the subject of research, the majority of studies (72%) between 1984 and 1989 failed to address gender differences in treatment outcomes (Toneatto, Sobell et al. 1992). Despite the gains made in gender-sensitive research on substance use, literature reviews reveal that many of the concerns articulated over the preceeding 20 years are similar to those identified in the 1990s (Hands, Banwell et al. 1995).

Thus, some publications continue to portray research that is principally an explanation of male use and appropriate treatment as an adequate explanation for the general human experience. It would be an oversimplification to see the changes to a more gender-sensitive pattern of research as a neat historical progression. Rather, the criticisms expressed in the 70s and 80s have lead to a smattering of changes which have increased the diversity of drug research and brought women much more into the picture. For example, during the 1990s in Australia there has been a steady growth in research which assesses women's treatment services and analyses ways to improve services for women (Baily, Saunders et al. 1991; Copeland and Hall 1992; Copeland 1994; Swift and Copeland 1996).

## **THE SOCIAL CONSTRUCTION OF GENDER**

Neither in Australia, nor elsewhere, has there been much theoretical focus on how gendered social institutions and cultural values interact with and shape non-medical drug use and misuse. Room (1996) notes that, even in 'gender-focused discussions of alcohol and other drug use and problems, the emphasis has usually been on the individual male or female or on the genders as aggregates of individuals'. Even to the present, the comparative levels of heavy drinking and drug use among men and women, with subsequent debates on the convergence of male and female patterns, have been a major strand of research (Fillmore 1984; Hughes, Day et al. 1997).

A small but growing number of studies have included insights on gender norms in relation to drug use but only rarely have these insights been drawn together into a coherent whole relating the drug user's experience to the gendered structures in society. Early research on women's drinking problems noted the greater stigmatising of female alcoholics compared to males (Lisansky 1957). Implicit in this observation was the recognition of the differential social expectations for the sexes which resulted in different social controls being imposed on women and men in relation to their drug use.

Yet there is still little research which sets out explicitly to consider the interaction and the effect of social and gender norms in drug use (Room 1996).

A social constructionist analysis focuses on the links between individuals and social control based on socially constructed definitions and explanations (Morrissey 1986). As yet, social constructionism occupies a small place in drug research. Yet, together with historical analyses, such studies provide a wider picture of drug use which, like much human activity, is complex, historical and gendered. Using intoxicants is a practice as old as human culture - as part of daily living (Warner 1992), in ceremonial contexts, to expand the mind, and to relax (MacAndrew and Edgerton 1969). Drug use reflects and is shaped by the culture in which it occurs. Both the types of substances used and the written and unwritten social sanctions regarding their use vary across cultures and have varied over time within cultures. Drug use is socially controlled for most people in most societies. Proper and improper uses of a particular drugs is socially defined and transmitted in almost every society (Gusfield 1963). Given that legal and other cultural norms play an important part in the use of alcohol and illegal drugs, it is perhaps surprising that to date so little drug research has considered how gender and social institutions shape drug using activities.

There are two concepts within a social constructionist perspective which have been used to theorise gender in relation to drug using in modern capitalist society. The first, which I will label 'dependency theory', is concerned with the dependent position of women in society (Ettorre 1992; Hatty 1993). The second are 'power theories' which are concerned with differences in attitudes towards drug using among less and more socially powerful people (Sargent 1979; Room 1980; 1992).

The main dependency theorist, Ettorre, argues that women's drug use must be understood in relation to the subordination of women by men and women's consequent dependence. She argues that *as a social group*, women are 'culturally, politically, and economically subordinate to and dependent upon men for survival' and that any women's issue, including substance abuse 'is necessarily defined by women's relationship to men' (Ettorre 1989:102). She notes, however, that women are not a homogeneous social grouping and criticises drug research pre-1990 for not paying attention to key social factors such as ethnic origins, age, social class, and sexual orientation. Thus, she argues that a full analysis of 'women and substance abuse must include both a structural and individual explanation' (Ettorre 1989:103).

Similarly, Hatty (1993) argues that women's dependence on men, the law and the state is socially constructed. Because much of the research and theorising about women's illegal drug use is based on the 'existing male-biased models', present knowledge about women's drug use is 'confined within the dominant discourses of gender and power, and fails to consider the broader questions about the concept of dependence and women's relationships to it' (Hatty 1993:28). In using dependency to theorise women's drug use, Ettorre and Hatty note that it grows out of the social inequalities between men and women, and women's relative lack of power in society. Thus, dependency theory is ultimately based on a theory of power relations.

The effect of power relations on drug use behaviour and attitudes has been explicitly theorised by writers such as Sargent and Room (Sargent 1979; Room 1980; 1992) who

see gender as just one factor in determining an individual's power or lack of it. For Sargent, 'theories, practices and policies towards drugs in society, in Australia and elsewhere, result from the historical development of power relations among social classes, racial divisions and gender groups' (Sargent 1992:10). Sargent first discussed the impact of power on drug use in her research on Australian drinking patterns which, she found, varied with gender, occupation, education and income. She argued that men's drinking patterns grew out of the historical image of the typical Australian male as a 'virile, mate oriented but heterosexual, hard drinking bushman'. Males achieved acceptance as adults and became part of the dominant male groups 'by exhibiting an assertive masculine stance' which was expressed in part 'through drinking without limiting one's intake in any apparent way'. Although there were 'many social class variations in 'location of drinking, type of drink and behaviour expected', nevertheless, 'pervading all classes', there was an association 'of manliness with drinking'. But there were different standards for subordinate groups such as women, Aborigines and young people who 'are often punished for drunkenness' (Sargent 1979:81-89).

In an examination of early colonial American drinking customs, Room (1980) noted that there were prohibitions on alcohol use for women and slaves which did not apply to white males. Similarly, Gusfield (1963:28-9) observed that 'alcohol has had a special function as a symbol' of the levels of social status, and the taboos against female drinking were 'one way in which American men symbolised their higher status (relative to women)'. Both Room and Sargent argue that subordinate groups are denied the right to drink or drink heavily and are punished (either formally or informally) more severely than the dominant groups for alcohol-related indiscretions.

A social constructionist analysis reveals how the gendered nature of the wider society is reconstituted in the attitudes and behaviour relating to drug use, such that the gender-specific norms of the wider society are translated to the drug field. For example, women's general social and economic dependence is translated into dependence patterns in drug use: women rely on male partners for introduction to illegal drugs, among other things (Ettorre 1992:81). There are a number of ways in which the gendered nature of the wider society appears in the drug using culture.

A male friend is most often the person to introduce both males and females to illegal drug use (Hser, Anglin et al. 1987), with boyfriends and spouses playing an important role in initiation for women. Early research indicated that most women began illegal drug use through their association with a male drug user (Suffet and Brotman 1976; Binion 1982; Reed 1985; Hser, Anglin et al. 1987), although Chein and associates (1964) found that this was true for a minority of women in their study. More careful analysis has shown that the predisposing factors vary for different groups of women and for different illegal drugs. In San Francisco, male partners were the most important source only for the women in the older cohorts - those over 25 years (Rosenbaum 1981) - and, in England only for those women who had entered drug treatment programs, but not for others (Parker, Bakx et al. 1988). Among Glasgow women, male drug using partners were instrumental in introducing the women to 'hard' drugs whereas first use of 'soft' illegal drugs generally took 'place with and through other females' (Taylor 1993).

Men also heavily dominate the drug distribution and dealing structures - the drug economy. Traditionally, drug selling has been a highly gendered activity (Preble and Casey 1969; Adler 1985; Anglin, Hser et al. 1987). Those women who are active in the drug market tend to be at the lower levels of the drug economy and are generally consumers as well as sellers (Erickson and Watson 1990). Men also frequently deal to support their use, but research in the Detroit Crack Ethnography Project found that almost twice as many men as women deal for profit (Mieczkowski 1994). The sexual division of labour prevails in both the licit and illicit markets, with the gender stratification in the labour market in the legal economy (Game and Pringle 1983) being accentuated in the drug economy (Sargent 1992; Maher and Daly 1996).

Thus, a gendered perspective indicates a number of ways that women's power to control their work and personal lives is limited to varying degrees by social structures and social relationships, both in the illegal drug worlds and in the wider society. A social constructionist approach, however, also recognises that individuals interact with and resist economic and social institutions in creating their own social worlds. In the drug field, there is evidence that some women resist the 'sex/gender system', to use Rubin's term, and have been able to make changes in their situation. Fagan has argued, for example, that the changing cocaine markets in the US provided new opportunities 'for women to escape their limited roles, statuses and incomes' compared to previous eras (Fagan 1994:210). A number of scholars have noted that some women have found productive niches in the cocaine market (Bourgois 1989; Fagan 1994; Mieczkowski 1994), thus altering the gender disparities in the drug economy, although Maher (1996) has questioned the degree to which women can attain and maintain an improved position in a male-dominated drug market with the associated beliefs and practices (including violence) which maintain it. She argues that 'assertions of women's changing and improved position in the drug economy have not been well proved. Nor are they grounded in theories of how work, including illegal work, is conditioned by relations of gender, race-ethnicity, and sexuality' (Maher and Daly 1996:485-6).

Maher's (1997) account points to some of the complexities of power which arises from a range of social differentiations and suggests that it is not only exerted in a top down fashion. A much more complex account of power is presented by Foucault (1981) who argues that it does not simply work as a 'binary system', repressing the 'illicit' and ignoring the 'licit' (1981:83) but primarily by a process of normalisation. Normalisation works equally on both sides of the binary division by, setting up a norm, as the central ideal position towards which people are 'pushed' (Bell 1993:30). In his analysis, Foucault warns

one should not assume a massive and primal condition of domination, a binary structure with 'dominators' on one side and 'dominated' on the other, but rather a multiform production of relations of domination (1980:142).

In his historical analysis of sexuality and the workings of power, Foucault (1981) takes it as read that sexuality is socially constructed but his concept of power conflicts with the notions of power presented by many feminists (Bell 1993:39), including the dependency theorists. The conflict arises because Foucault dismisses the ruler/ruled concept of power as a remnant of 'juridico-discursive' power remaining from the times when the King's word was law (Foucault 1981:88-91). It is precisely this notion of a hierarchical binary division of power which may be seen in feminist analyses, in which

men are theorised as having power over women (Bell 1993). Foucault's concept of power is much more complicated, mobile and unstable than that suggested by juridico-discursive models of power. While it is not pertinent here to explore in detail the complex and problematic nature of the Foucauldian notion of power (see Bell (1993:25-28; 37-42) for a review in relation to feminism), it is relevant to mention the notion of resistance which is central to his concept of power. For Foucault, power does not exist without resistance. If there were no resistance, there would be no need for power to operate. Thus, resistance is not outside power, working against power from without, but in a relation with power. In this analysis, power is understood as a 'a multiplicity of points of resistance' that 'are present everywhere in the power network' (Foucault 1981:95), with a 'multiplicity of force relations' (1981:92).

Ettorre's book on *Women and Substance Use* represents an example of some of the problems associated with the positioning of power in feminist accounts of gender and drug use. Ettorre sets out, among other things, to 'highlight the social construction of gender' in 'substance use' (1992:15), but in so doing, she concentrates on women's dependency, their powerless position, and neglects to recognise examples in the drug literature of resistance by women drug users to the gender system. Ettorre's account of the literature on women's initiation into illegal drug use demonstrates the point. She states:

Research literature reveals that the majority of both male and female addicts are initiated into drug use by a man (Hser, Anglin and McGlothlin, 1987). ...women who begin daily use of heroin do so mainly because it is easily available - they are living with a male dealer or user who induces them to use 'smack' (Ettorre 1992:81).

In this picture, women heroin users are portrayed as dependent, passive victims induced into heroin use by males. But, while it is true that the 'majority view ..... is that women are mainly introduced to drug use by males' (Taylor 1993:32), the story of women's beginning drug use, even in the 1970s and 80s, is much more complicated. Rosenbaum, for one, found that in her San Francisco sample only the women over 25 years of age had been initiated into heroin use by males. In a later publication in 1990, Rosenbaum argues that '[o]ccasionally, women are introduced to heroin through a boyfriend or spouse, but this research found that this does not occur as often as the literature suggests' (1990:122).

In arguing her case for women's dependency in substance abuse, Ettorre neglects or overlooks the research which provides glimpses concerning women drug users's resistance to gendered structures and the interplays of power. Her account is essentially a liberal feminist approach to gender and substance abuse. She presents the case arguing that women are dependent and suggests consciousness raising as one solution in her chapter on *A feminist response to substance abuse* in which she presents eight strategies for developing 'awareness of the key political concerns and strategies' (Ettorre 1992:144). Ettorre's occasional comments about resistance demonstrate her liberal feminist response to concern about, for example, that 'theory building in the alcohol field is fundamentally a male preserve' and consequently she argues that there will be resistance encountered 'in viewing women and alcohol as a political issue' (1992:33).

Recognition of the diversity of women's beginning drug use experience, however, would not necessarily negate her argument. Rather, it can be used to demonstrate the variety of ways in which different categories of women deal with gendered social structures and to provide examples of the 'multiplicity of force relations'. There are glimpses of resistance to the restrictive gender expectations imposed on women drug users in quotes from women drug users in a variety of drug literature, including Ettorre's work. However, neither Ettorre nor earlier writers have addressed resistance to the traditional sex-specific gender norms in any coherent or theoretical manner. As a 'resistance perspective' has only recently begun to gain ground, much of the earlier interview data could be reinterpreted within this framework (Friedman and Alicea 1995).

A resistance framework has been used by Friedman and Alicea (1995) in explaining the accounts of 30 white middle and upper class female heroin/methadone users in the US. Their analysis shows that 'these women maintain multiple interpretive frameworks for constructing their identities and resisting class and gender domination' (p. 433) and that the main forces shaping their experiences are gender, the social world of heroin, and the dominant culture (p. 436)

In conclusion, I argue that in examining gender and illegal drug use, social construction provides a helpful tool in explaining women's experiences when one recognises that the social hegemonies are a major but only one of the forces of power in play.

## **ORIGINS AND PURPOSE OF THE STUDY**

The research for this thesis developed out of my experience working on a epidemiological pilot project studying illegal drug use at the Australian Institute of Criminology. This project, the ACT Drug Indicators Project, was established to develop and refine methodologies for estimating the incidence, prevalence and character of drug use (principally illegal drugs), and to construct and monitor indicators of changes in the drug use levels and patterns over time (Stevens 1991). The project was the first Australian effort to devise methods for monitoring changes in illegal drug use patterns using multiple indicators. At the time, I was struck by the fact that the study of illegal drug use has been closely tied in to the study of crime, and in this context, women were practically invisible and irrelevant.

Thus, this thesis sets out to provided a gendered analysis of the illegal drug field in two ways. First, I examine the data gathered by the agency study of ACT Drug Indicators Project in terms of the epidemiology of illegal drug use among women; that is, I analyse critically the data set and its adequacy as a means of monitoring the incidence, prevalence and character of illegal drug use among women. In doing this, I note the gendered social construction of the data sources and argue their relevance to developing indicators of illegal drug use.

Second, in analyses of interviews with women illegal drug users and treatment workers I conducted, I explore issues that have previously been neglected in the studies of illegal drug use. This component of the thesis addresses facets of drug use that have previously been ignored when the agenda for research reflected the drug users experiences only of males, as occurs within the Drug Indicators data set. In undertaking

this second task, I explore the women's experience with the gendered social structures, providing examples of the variety of ways power is mediated, particularly in relation to sexuality and stigma issues.

## OVERVIEW OF THE STUDY

The study uses a variety of methods to provide new perspectives on illegal drug use. Triangulation, that is examining a research topic by a number of different methods and from a number of different perspectives, is a well accepted technique for creating a more comprehensive picture of the phenomenon under study (McDermott 1991). The approach taken in this study accepts the poststructuralist notion that there is no single objective 'truth' to be discovered but that research provides a range of knowledges that can inform our understanding of the matter under study. Triangulation is both a recognition of the plurality of knowledges and an attempt to assemble a more detailed understanding than any single perspective can yield.

In this study, I use two different strategies to add to our knowledge of illegal drug use; one quantitative and the other qualitative. The quantitative study relies principally on data collected by the ACT Drug Indicators Project, an epidemiological project on illegal drug use in Australia. The project generated a large data set on illegal drug use from agencies with whom illegal drug users come in contact. It is rare in Australia to have sufficient data to allow testing for significant statistical comparisons between men and women for a variety of illegal drugs; or to be able to take into account factors such as gender, age, type of drug, criminal and treatment history. The ACT Drug Indicators Project data set has these properties and thus I was able to conduct a quantitative analysis comparing men and women's illegal drug use while controlling for other factors. In addition, I examine the data set as an appropriate vehicle for monitoring the levels and patterns of *women's* illegal drug use, thus addressing the question of gender in the study of the epidemiology of illegal drug use. That is, I do not assume that the epidemiological methods on which the ACT Drug Indicators Project are based are gender neutral, so I examine how appropriate the methodology is in monitoring women's use of illegal drugs.

However, the Project data is not ideal for my purposes. The two most important limitations of the data set relate to the historical background of drug treatment and research. First, the project was confined to collection of data that was common to all the participating agencies. Second, the variables collected reflect the previous agendas in drug treatment and research.

The qualitative part of my study was an interactive process with women who were illegal drug users either in the past or when I interviewed them. This part of the study seeks to redress some of the constraints from the first part of the study.

## ORGANISATION OF THE THESIS

I begin, in Chapter 2, by reviewing theories of drug use and dependency which have been important in framing the way illegal drug use is seen by researchers, by those who use illegal drugs, by staff in drug treatment and criminal justice agencies and by those in the wider society. These theoretical perspectives each comprise a discourse, that is, a

patterned 'system of language which cohere around common meanings and values' that 'are a product of social factors, powers and practices, rather than an individual's set of ideas' (Hollway 1983). In other words, the language in any discourse is characterised and unified by common assumptions. Social constructionist accounts have demonstrated the links between scientific discourse, the relations of power, and the exercise of social control (Gusfield 1981; 1991). They show that 'cultural categories and stereotypes are reflected in and supported by scientific discourse and then applied in social responses to conditions and individuals defined as problematic' (Morrissey 1986:157). I examine some of the drug theories, and the discourses imbedded in their application, which are gendered in particular ways and suggest implications for improved drug treatment practices and research. I argue that multiple models of drug use co-exist because they are applicable to and provide a discourse for different sections of the drug community.

Chapter 3 addresses questions of measuring illegal drug use and describes the study design for the quantitative and qualitative data sources used in this project. The chapter begins by drawing on the international literature describing the use of multiple indicators to estimate trends in illegal drug use, and places the ACT Drug Indicators Project in the development of epidemiological methods, such as the use of multiple indicators, for measuring the level and nature of illegal drug use in Australia. The second part of the chapter explains the rationale for the qualitative study and describes the study design.

In Chapter 4, I examine drug indicators data from a gender perspective. I compare the data collected via the health and welfare system with the law enforcement data collected by the ACT Drug Indicators Project with the purpose of assessing appropriate methods for monitoring both men's and women's illegal drug use. I argue that drug indicators data could fail to measure adequately women's drug use unless appropriate attention is paid to the gendered nature of the data sources. I suggest that the social construction of the data sources, in this case the gendered nature of the criminal justice system, influences the type of data available and therefore can bias the inferences on the epidemiology of drug use in the community.

Chapters 5 and 6 examine the process of beginning drug use. Chapter 5 considers the legal drugs - tobacco and alcohol, and Chapter 6 addresses the experience of moving on to illegal drugs. I use the quantitative data from the ACT Drug Indicators Project to compare males and females beginning drug use, and draw on the qualitative data from the interviews to explore gender and a range of other issues in beginning use. These chapters use a social construction approach to explore the dynamic process between the women and the overarching social constraints such as the construction of femininities as the women develop notions of what they see as acceptable drug use and acceptable femininity.

Chapter 7 addresses sexuality, stigma, abuse and shame issues arising out of the drug using and sexual experiences of the women in the field study. I begin by examining the issues of stigma and shame in general and in relation to drug use and sexuality. In the second section, I explore the suggestion by some women that their drug use and intoxication was influenced by their uncertainty about their sexuality as desirable heterosexual women. I also consider how the women believed that their drug use was



seen by many others as marking them as 'sluts' and sexually available, and how those attitudes were associated with various types of sexual assault ranging from sexual harassment to rape, and how the women deal with these attitudes and behaviours. In the third section, I explore the experiences and responses of the women to stereotypes about women who are drunk or using illegal drugs. Finally, I examine how the women deal with sexual stigma in drug treatment recovery

Chapter 8 concludes by drawing together the effects of social constructionism in drug discourses, theories, attitudes and behaviour of men and women who use illegal drugs and those who interact with them.

## TERMINOLOGY

### *Drugs*

As this thesis contains a review of past theories of drug use and drug dependence, I have chosen to retain the terminology of the period where appropriate. Therefore, as was suggested previously, at times I use the terms 'alcoholic', 'alcoholism', 'addict' and 'addiction' rather than the term which is presently accepted: 'dependency'.

Dependence is defined as a 'socio-psycho-biological syndrome manifested by a behavioural pattern in which the use of a given psychoactive drug (or class of drugs) is given a sharply higher priority over other behaviours which once had significantly greater value (i.e. drug use comes to have a greater relative value)' (Edwards, Arif et al. 1982:19).

Recently, chemical dependency has come to replace the term addiction (Reed 1985:18; Bailey 1989). In this thesis, I use the term chemical dependency to indicate dependency on either or both alcohol and other drugs. Bailey notes that

there is a growing consensus in the field that all compulsive abuse of mind-altering substances is part of a single biopsychosocial disease called *chemical dependency*. This generic term replaced the older more pejorative term *addiction* and describes the compulsive use of chemicals and the inability to resist the impulse to use them despite negative consequences in major areas of one's life (1989:151) (emphasis in the original).

In this thesis, the principal emphasis is on illegal drugs but it is an artificial distinction created by the laws and culture. For people who use illegal drugs, the distinctions are not as important. There is an interchange between types of drugs. For adolescents, it may be alcohol, cannabis and/or amphetamines depending on the stage of experimentation. For dependent users, it may be the substitution of alcohol or benzodiazepines for heroin. In addition, multiple drug use of both legal and illegal drugs is common. Thus, while the study is principally about illegal drug use, I have not ignored the legal drugs which are intertwined in the use patterns of the people in this study.

In examining the epidemiology of illegal drug use, I have been concerned with prevalence and incidence. Prevalence is defined as the number of users of the various drugs at any given time, or use rates in the population as a whole. Incidence refers to the rate at which illegal drug use is increasing, or the numbers entering the drug-using population (Blackwell and Erickson 1988:211).

There has been a time, and there are still some places, where the word 'drugs' implies illegal drugs. As may have been already noted, in this thesis, I use the term 'drugs' to include both legal drugs (such as alcohol and tobacco) and illegal drugs. In differentiating illegal drugs, I could have used the term 'illicit drugs' which is a legal, rather than a medical categorisation (Manderson 1993:11). I have chosen generally to use the term 'illegal' rather 'illicit' except where appropriate in discussing drugs and the legal system. In this discussion of the definition of drugs, I have attempted to demonstrate that the terminology is not simple, being overlayed with various and competing cultural meanings.

### **Gender**

Nor is the definition of gender simple. There is considerable debate and some confusion over the meaning of the terms sex, gender, gender difference, sex roles and sexuality, and the theorisation of these terms is central to much recent feminist debate (Franklin 1996). I use both the terms sex and gender but not in any strict sense. The distinction between sex (such as used in the categories male and female) as a signifier of biological difference and gender as a term to encompass the ways the social system organises and gives meaning to these biological differences has been questioned and shown to be problematic by Gatens (1983) and others (Edwards 1989; Thompson 1989; Grosz 1994). Grosz (1994) sees sex and gender as being inextricably interwoven from birth in the ongoing process of the creation of the self(s). But this does not mean that gender identity necessarily arises out of so called natural or biological difference. It is not appropriate here to discuss the extensive literature in feminist theory on this topic, but simply to note that gender is a complex construct which can not simply be explained by the supposedly dual categories of masculinity and femininity. As Connell argues, 'the social relations of gender are not determined by biological difference but deal with it; there is a practical engagement rather than a reduction' (Connell 1985:139-140). To elicit a clearer understanding of the meaning of gender as it pertains to this thesis, I address the critique of 'sex roles' theory and subsequent theories on the gender system.

The concept of 'sex roles', as defined by Parsons (1942; 1951), was used to describe what is now commonly referred to as gender difference (Franklin 1996). According to the Parsonian theory, men and women are socialised into sex-specific roles which govern their behaviour and identity. Thus girls become feminine by internalising the 'female role'. This theory connects social structure (with socialising agents such as the family, school, films etc) with the formation of personality via the idea of role learning or internalisation (Connell 1985).

Feminist theorising has raised a number of concerns regarding the Parsonian theory of complementary male and female roles (Lopata and Thorne 1978; Edwards 1983), one of which relates to the masking of male power. Sex role theory highlights differences between the sexes and their situations which are seen as being for the benefit of the overall social order, and ignores the relations of power between the sexes. As Carrigan, Connell and Lee note 'the political effect is to highlight the attitudes and pressures that create artificially rigid *distinction* between men and women and to play down the *power* that men exercise over women' (1985:580).

The gender order is a more productive way of conceptualising gender. The gender order arises from and consists of historically constructed patterns of power relations

between men and women. It is 'an initial social differentiation that permeates and underpins all other distinctions' (Matthews 1984:13). The dichotomy of men and women is an important part of gender order, but it does not simply consist of the dual categories, masculinity and femininity, for gender practice can be organised in any number of gender categories - 'girls, old men, lesbians, husbands and so on' (Connell 1987:140).

Connell identifies a number of different masculinities and femininities but, in the contemporary capitalist world, he notes, the interrelationship between masculinity and femininity 'is centred on a single structural fact, the global dominance of men over women' (Connell 1987:183). The dominant form of masculinity, which he defines as hegemonic masculinity, is constructed in a relation of dominance to the various subordinated masculinities and to women. The concept of hegemonic masculinity should not be seen 'as 'the male role' but as a particular variety of masculinity to which others - among them young and effeminate as well as homosexual men are subordinated' (Carrigan, Connell et al. 1985:586). Hegemonic masculinity provides a collective ideal, against which men live their actual lives.

Prevailing forms of femininity and masculinity provide standards and ideals against which men and women are constantly being scrutinised, by others and by themselves. According to Matthews

For women, the gender order of any particular society creates an ideology of femininity, which establishes both the imperative and the meaning of being a good or true woman. This ideology is a patterned set of ideas and beliefs about women that influence both the behaviour and the treatment of all women in the society (1984:15).

The gender order, then, is 'a systematic process of power relations that, for the individual, begins at birth and turns barely differentiated babies into either women or men of the approved type, thereafter keeping them to the mark as the definitions change' (Matthews 1984:13). For females, value constructs such as 'lady', 'nice girl' are learned 'both a standard for and a goal of behaviour' (Fox 1977). As Stephens (1988: 90) notes 'appropriate behaviour for women has been both differentially defined and more narrowly circumscribed than for men'. Women who are drunk or using illicit drugs are regarded with greater moral concern than men similarly intoxicated (Erickson and Murray 1989; Ettore 1992). The stereotypes of women in Australian society as either Damned Whores or God's Police (Summers 1975) still prevail in the drug field (Sargent 1979:119-120). These societal views on acceptable and normative behaviour for the different sexes also indicate how definitions of sexuality are also implicit in the construction of gender.

Thus, types of femininity and masculinity are formed in particular milieux which are constituted out of a variety of gendered social structures. Class, race/ethnicity, the school and the work world are all gendered and the power relations in these social structures 'cut across the gender order and deflect and modify it. Only within a specific group of men and women who are otherwise equal is it possible to see gender domination clearly' (Matthews 1984:14).

The resulting tangle means that power and gender relations are infinitely complicated. Thus, in the struggles for power, we are shaped by the social structures around us but

also we resist and change them. There are a variety of possibilities in our gendered worlds and women, including those in the drug using worlds, make choices creating various versions of femininity.

In this thesis, I am not only concerned with gender as the property of a 'socially produced individual character' but also as a 'property of collectives, institutions and historical processes' (Connell 1987:139). In this approach, gender is not only used as a noun but also to describe a process, a practice - a particular way of organising life. Thus, I also address the gendering of social practices and institutions.

The gendered nature of the drug field has been an increasing topic of interest for the last two decades and is gradually becoming a subject for serious investigation. This thesis addresses the social construction of gender in drug theories and the epidemiology of drug use, and also the varieties of ways women drug users acquiesce and resist the gender order and constitute themselves in the illegal drug worlds.

## CHAPTER 2: THEORIES OF DRUG USE AND DEPENDENCY: MOVING TO A GENDERED PERSPECTIVE

The history of the development of theories of chemical dependency and illegal drug use is relevant to an understanding of the present inadequate knowledge of women's illegal drug use. In this chapter, I review the history of drug research and the different theories which sought to explain drug use and treat chemical dependency. The models of drug use which I will explore are (a) the disease model, (b) moral models, (c) the drug career model and (d) the pleasure model. This is by no means an exhaustive list of the possible theories relating to drug treatment. For example, the disease model is one approach to a pathology perspective of illegal drug use. My aim in reviewing theories about drug use is not to provide a comprehensive analysis of drug theory and how it is applied in drug treatment setting but rather to highlight the gender aspects of the historical background and explore the intellectual and discursive context to which women who use illegal drugs are exposed. I conclude this chapter with a re-examination of the disease and pleasure models where gender is taken into consideration.

Research into alcohol and other drug use and treatment for problematic use began in a serious way in the United States in the 1930s and 1940s as part of the rise of medical dominance in a variety of health and social welfare fields (Willis 1983; Edwards 1988: 160–1). The first modern journals devoted to reports of treatment and research into drug problems were established in this period. The pioneer journal in the US drug field, *The Quarterly Journal of Studies on Alcohol*, was established in 1940 and the pioneer British journal, the *British Journal of Addiction* was first published in 1947.<sup>4</sup> Medical practitioners were the most common treatment providers and researchers, patients were generally the treatment subjects, and alcoholism the most common drug problem. During this period, for the first time, psychiatrists and other medical practitioners came to identify the drug and alcohol field as a specialist medical area. Part of the growing professionalism of this early period was the development of theoretical explanations of drug use and addiction, beginning with the disease model of addiction.<sup>5</sup>

### THE DISEASE MODEL

A major theoretical development in the drug field occurred in the 1940s with Jellinek's presentation of the disease model of addiction (Jellinek 1946). Previously, alcoholism was regarded as immoral, and the alcoholic or drug user as a reprobate. This position was reflected in the latter period of the Temperance Movement when alcohol was seen as evil, and among some Temperance groups, people were encouraged to take the 'pledge'—to abstain from alcohol.<sup>6</sup>

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4 The *British Journal of Addiction* was preceded as the *British Journal of Inebriety* from 1903–1946. In the US, a similar type of journal, *The Journal of Inebriety*, published irregularly from 1876 to 1914 (Jellinek 1960:2).

5 The following section on the various models of drug use has been revised and expanded from a paper, titled *Models and Explanations of Drug Use* (Stevens, 1991) prepared as part of the research into the Feasibility Research into the Controlled Availability of Opioids and published as Appendix B in the background papers of Stage 1 of the research (National Centre for Epidemiology and Population Health 1991).

6 Early temperance groups saw heavy alcohol use as the problem and developed the pledge to refrain from distilled spirits. The pledge to abstain from alcohol completely was a development taken up by later temperance groups (Blocker 1989).

By contrast, according to the disease model of addiction, addicts are sick, mentally, physically, or both (Riley and Marden 1946). Thus they deserve help, not condemnation for their addiction. Jellinek (1946) is widely credited with developing the model of alcoholism as a disease. He described various phases in the drinking history that leads towards alcoholism. It was the two last stages of this process into 'gamma alcoholism' which he labelled as a disease (Jellinek 1946; Jellinek 1960:37). Jellinek adopted the newly accepted scientific methodology, an empirical study, to explain alcoholism, thus giving scientific legitimacy to the disease model. However, the concept of alcoholism as a disease began much earlier (McAllister, Moore et al. 1991:2). In 1890, for example William Booth, founder of the Salvation Army, supported the concept of the 'disease' of drunkenness and affirmed the need 'to bear upon it every agency, hygienic or otherwise, calculated to effect a cure' (Booth quoted in Drew 1986).

Levine argues that the notion that 'alcoholism is a progressive disease ... whose only remedy is abstinence ... is about 175 or 200 years old, but no older' (1978:143). In the 17th century and for most of the 18th century, 'habitual drunkenness was regarded as natural and normal - as a choice made for pleasure'. Liquor was a normal part of living: a food, medicine and social lubricant (Warner 1992). People drank and got drunk because they wanted to and because they loved to drink, not because they 'had' to or could not stop themselves (Levine 1978:144). By the 19th century, the notion of drunkenness as due to an overwhelming and irresistible desire for liquor was beginning to develop and was a 'major strand of 19th century thought - the ideology of the Temperance Movement' (Levine 1978). But the Temperance Movement located the source of the addiction in the drug (alcohol) whereas in the post-Prohibition era the source of the addiction was located in the individual body of the alcoholic. This new disease concept represented a shift in the concept of addiction but, Levine argues, it was 'still well within the paradigm first established by the Temperance Movement'.

The notion that drunkenness and problematic alcohol use could be explained as a sickness, a disease to be treated, rather than a signifier of 'a bad person' was one of the principal reasons for the acceptance of the disease theory by patients and clinicians. Drew, Senior Medical Adviser for the Drugs of Dependence Branch of the Commonwealth Department of Health in the 1980s, summarised the factors he saw as associated with the development of the disease model in this century:

The disease concept, as it applied to a self-destructive drinking pattern, was introduced as a reaction to overt moral condemnation or sheer neglect and indifference ..., to inspire the hope of effective treatment ..., to avoid guilt, shame and stigmatization, ... and to justify attempts at constructive intervention. It authenticated drug use as a medical problem, and stimulated scientific enquiry into the aetiology and treatment methods (including their evaluation) (Drew 1986).

However Krivanek (1988) argues that accepting the sick role (Parsons 1951) entailed in the disease model has some negative trade-offs for chemically dependent people. For example, they hand over some control and responsibility for their lives to clinical staff and so 'the disease model fosters a dependency that is counterproductive to treatment' (Marsh 1982). 'Sick' people can no longer be blamed for their drug problem but the responsibility for recovery is shifted to the health professional. The addict has the

responsibility to seek and cooperate in treatment but 'he or she does *not* have to get well' (Krivanek 1988: 204 - emphasis in the original).

This view, however, is contested by disease theory proponents such as members of Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) who argue that the addict is not responsible for having the disease of addiction but they *are* responsible for their recovery, for doing something about it (pers. comm. Toora Women's Addiction and Recovery Service). This two pronged approach is summed up in the philosophy of the Alcoholics Prayer which is:

God grant me the serenity to accept the things I cannot change, the courage to change things I can, and the wisdom to know the difference.

The first part of the prayer expresses acceptance of the disease of addiction and all that it has entailed - whether it means being drunk in the gutter, stealing to supply an addiction or simply selfishly putting oneself before family and loved ones and doing them harm. It can also entail accepting the reality of an abusive childhood (often growing up in an addicted family) and the subsequent need to blot out these realities with drugs of any type. Acceptance of the disease of addiction was one way of coming to terms with an unpleasant past - learning 'the serenity to accept the things I can not change'.

The second part of the prayer involves addressing the knowledge of addiction and having 'the courage to change the things I can'. Taking control of ones life and making changes is not easy - as the relapse rate back to destructive drug use testifies (Young 1990; Baily, Saunders et al. 1991; Saunders, Baily et al. 1993). Nevertheless, for many chemically dependent people, the disease theory presents an illuminating explanation for their past behaviour, and shows an opportunity for a new and better life without drugs. Addicts (a name they take for themselves) come to realise that they do not have to remain in what they now see as a self destructive lifestyle. But the new knowledge and motivation is only the first step in recovery. The responsibility to put the knowledge to use and change one's life lies with each addict and the path to recovery can be rocky and difficult to negotiate. The ups and downs in the path to recovery require vigilance to avoid falling into old habits and support from new friends to avoid relapse. To argue that someone in recovery from addiction has handed over responsibility to treatment staff is a vast oversimplification.

Although responsibility lies with each addict for their recovery (Al-Anon teaches this to relatives and significant others), support is an important element in recovery. Thus, in AA and NA the twin elements of both knowledge (the disease theory) and support (from fellow members) provide a powerful incentive and tool for recovery and perhaps, in part, explain the success of the disease model. The popularity of AA, NA and the disease model attests to the relevance of the disease model to a substantial proportion of those with chemical dependency. In 1995, AA celebrated its 50th birthday in Australia and announced that 'about 40,000 Australians attend some hundreds of meetings around the country with 400 meetings a week in Sydney alone. The first AA group in Canberra was set up in 1953. AA holds more than 50 meetings a week in Canberra.' (*The Canberra Times*, April 15, 1995, p.3).

Nevertheless, among researchers and treatment professionals, the disease concept increasingly has been criticised over the last thirty years, and there have been a number of attempts at modifying or overthrowing it (Drew 1986). One change has been the development of the view that 'the abnormality involves both a biological component and aberrant learning' (Edwards and Gross 1976), which has led to a psychosocial approach (Saleeby 1985) for treatment. Alexander (1987) suggests replacing the disease model with an adaptive model which conceptualises addiction as a way of coping. According to this theory, addiction results from adapting to a faulty environment, either faulty upbringing, environmental inadequacy and/or genetic unfitness. Although Alexander alters the analysis of the disease model to include social factors, he still conceptualises the drug user as a person with a problem, at odds with society.

A major weakness in the disease theory arose from the finding that some individuals diagnosed as alcoholics have been able to return to harmfree patterns of drinking which they have maintained over an extended period of time (Heather and Robertson 1983; Ali, Miller et al. 1992). According to the disease theory, the only solution for alcoholism is total and lifelong abstinence because alcoholics are thought to possess some inherent constitutional problem which prevents them ever drinking normally. However, research has shown that a proportion of people defined as alcoholics were able to move to safe and limited drinking. Critics of the disease model such as Heather and Robertson (1983) argue that there is no upper limit to the level of alcohol dependence which absolutely precludes a return to controlled drinking, although they concede that the event becomes increasingly rare with ascending levels of dependence.

Cognitive-behavioural approaches to treatment introduced in the 1970s adapted these findings by incorporating the option of controlled drinking as a treatment alternative. Behavioural models employ social and cognitive learning theory, and this approach is moving away from the disease model. Behavioural therapists argue that the disease theory is defunct (Heather, Batey et al. 1989:31) and that:

The *cognitive-behavioural* approach offers the best prospects for an overall improvement in the effectiveness of interventions for drug and alcohol problems. This is because (i) it is founded on a coherent and empirically-based theory of behaviour change and (ii) the effectiveness of several of the treatment methods derived from this approach has been confirmed in properly-designed controlled evaluations. The application of cognitive-behavioural treatments is supported by a greater body of evidence than any other treatment approach in this field (Heather, Batey et al. 1989).

Nevertheless, even in treatment agencies which provide behavioural therapy and controlled drinking as a treatment options, abstinence and the support of self-help groups like AA and NA remain treatment options. For those with high levels of dependence, abstinence is generally the recommended treatment as it is the less risky option for these clients since the likelihood that problem drinkers can sustain harmfree controlled drinking patterns falls as the level of dependency increases.

Because of the difficulties associated with the disease model (Whitelock 1980; Drew 1986) in 1964, the World Health Organisation (WHO) recommended abandoning the term 'addiction' and 'alcoholism' (World Health Organisation 1964; Edwards, Arif et al. 1982), and replacing it with the concept of 'dependence'. Part of this new paradigm



was a move away from using the terms addict and alcoholic because of the stigma involved in these terms. As I show in Chapter 7, changing the language has not necessarily removed the stigma from illegal drug use and alcoholism - particularly not for women.

Despite the changes recommended by the WHO and the development of behavioural approaches to treatment, the disease model persists and still holds an important place in the treatment practices of many alcohol and drug treatment services (Krivanek 1988; O'Malley and Mugford 1991). Moreover, in a substantial proportion of drug treatment organisations (particularly therapeutic communities and self-help groups such as AA and NA), the disease theory remains an important element in the theoretical explanation for 'addiction' and abstinence the recommended cure. In Canberra and Australia generally, approximately a quarter to a third of the drug treatment agencies maintain an abstinence/disease model philosophy (Crawford and Bammer 1991:202; Swift and Copeland 1998). The Canberra agencies which do not predominantly espouse the disease model fall into two types: non-government agencies who usually support a harm minimisation philosophy (including 'user groups' and needle exchange programs), and government agencies which are predominantly staffed by professionals such as psychologists and social workers offering cognitive-behavioural therapy among other modalities. Some practitioners in these agencies may use a disease model to inform their practice but it is not a common practice. Whereas the remaining agencies, which include those with a feminist perspective, rely on the disease concept as a central part of their practice.

In summary, a pathology paradigm, arising out of a medical/scientific discourse, remains a major theoretical perspective in drug treatment programs, although moral condemnation has not disappeared (McDonald 1994:5). For example, a survey of drug and alcohol program professionals in the 1980s in the US found that 'most alcohol and drug program workers still believe that alcoholics are in some fashion responsible for their plight and (inferentially) can somehow will themselves to recovery' (Tournier 1985:45). The disease model of addiction did not replace a moral view but exists as a competing and overlapping theoretical perspective.

## **THE MORAL MODEL**

Krivanek (1988) and others (Siegler and Osmond 1968; Blackwell 1988) use a moral model to explain a number of other approaches to illegal drug use. As noted in the previous section, moral positions on addictions have been around for a long time, and Krivanek argues that the classical notion of 'man, knowing good and evil, must be held responsible (and must be punished, whether by God or the community) for acts performed with a guilty state of mind has persisted in the criminal laws governing major offences' (Krivanek 1988:206-7).

These concepts of moral responsibility form the basis for moral models such as the enforcement model and the prevention model.

The enforcement model assumes that harmful drug use is a consequence of the moral weakness of human beings, so the law acts as a deterrent against using illegal drugs, not only against addicts but also those who might become addicts. Those who 'are found

guilty of violating the drug laws' are justly punished. The assumption is 'that if the punishment is severe enough addicts will know they have done the wrong thing and refrain in future' (Krivanek 1988:209). In addition, others will be deterred from trying illegal drugs because of their wish to avoid punishment. An example of the deterrence philosophy was demonstrated by the police in Canberra, the majority of whom opposed a proposal to prescribe heroin to dependent users because it would 'set a bad example for young people' (Stevens, Ostini et al. 1995). Similarly, in a survey of the general community, 40 per cent expressed concern about setting a bad example for young people (Crawford and Bammer 1991:218). According to the enforcement model, because humans are weak and can not easily resist the temptation to use and supply illegal drugs, the police and the legal system are charged with the responsibility for controlling the drug problem (McAllister, Moore et al. 1991). This model has been the main means of managing illegal drug use in the US since the Harrison Act of 1914.

The preventive model is also based on assumptions about moral responsibility (Siegler and Osmond 1968; Krivanek 1988). According to this model, 'drug addiction represents faulty moral education. Young people experiment with drugs because they have not been properly informed about the evils of drugs, or instructed in the seriousness and immorality of drug taking' (Krivanek 1988:209). Thus the solution to problem drug use is in the community - with families, schools and other education sources.

## **AN INTERNAL VALUES MODEL OF ADDICTION**

Peele (1988) presents a different analysis of the place of moral values in controlling addiction. He sees personal values as holding an important place in explaining why some people control a tendency to addiction (both to drugs and to food) and others do not. However, he tends to locate the source of control more with internal moral values than with an external force or moral lecturing such as the 'just say no' slogan (Peele 1988:226–228). He recognises the place of social forces for individuals in creating moral values, for example, in relation to moderation, as occurs in certain societies such as Jewish or Chinese-American communities. Compared to other social groups such as the Irish, he argues that in Jewish and Chinese society there are strong cultural sanctions against excessive consumption. Through the social group, people in these societies grow up internalising values of moderation that are inconsistent with 'loss-of-control drinking'. He argues that the disease model has been counter-productive because it negates the role of the individual's moral values in taking control of their addiction. This approach rejects the biological determinist explanation of addiction and uses a moral analysis to explain why many people give up harmful drug use without the need for treatment services. In Peele's model, the social norms of the cultural group inculcate moral values about moderation which provide powerful incentives to assess and take control of one's drug use before it becomes excessive or to moderate it if it becomes incompatible with the self definition acquired in the group of cultural or ethnic origin (Peele 1988:215).

## **THE DRUG CAREER MODEL**

The analogy of a 'career' to describe the introduction and passage into the world of illegal drugs has a long history in drug research. Becker (1953) was the first drug

researcher to use the metaphor to illustrate how 'becoming a marijuana user' involves learning the skills and norms of the drug using group, just as a person entering a new occupation develops the skills and norms of an occupation or a profession. In describing the process of learning to be a marijuana user, Becker (1963), delineated three stages in the career of a marijuana user: the beginner, the occasional user and the regular user. Each of these stages represented a distinct shift in 'relation to the social controls of the larger society and to those of the sub-culture in which marijuana use is found' (Becker 1963:61).

A somewhat more literal use of the career concept was applied by Preble and Casey (1969) to illustrate the life of lower class heroin users in the slums of New York City. Whereas Becker used the career concept to describe how males entered the social world of illegal drug use and gained the skills to participate in marijuana use, Preble and Casey compared the life of the heroin user to that of a 'working man' involved in 'a career that is exacting, challenging, adventurous and rewarding' (Preble and Casey 1969:2). Not only did men in a 'heroin career' gain skills but they also earned a living, an alternative occupation, which brought respect in their social world.

Preble and Casey challenged the accepted stereotype of the heroin user as a passive, inadequate person who uses heroin as 'an escape from life', from 'psychological problems and the responsibilities of social and personal relationships' (Preble and Casey 1969:2). They studied a group which they claim comprised 'at least 80% of the New York City's heroin-using population'. Contrary to popular opinion, the drug scene provided a meaningful, active and interesting life. At the time, heroin was expensive and of poor quality. To obtain some brief moments of euphoria, the street user had to become actively involved in his 'career with heroin' - hustling for money, avoiding the police, copping (buying heroin), looking for a safe place to take the drug - among other things (Preble and Casey 1969:2).

Similarly, Sutter (1966) found that among street users of heroin, there is high prestige and symbolic success for the 'dope fiend', the heroin user who 'has mastered the art of hustling'. He uses the most expensive narcotics in the country and he is ranked by his colleagues as the most versatile of hustlers in the street scene. In contrast, the role of the sick addict is taken by the user when he quits using drugs. Sutter concluded that the drug user is seen as a failure, a retreatist, when he stops using drugs, not when he starts or continues using.

Thus, studies among the slum neighbourhoods of US cities (Sutter 1966; Feldman 1968; Preble and Casey 1969; Agar 1973; Waldorf 1973) provided another view of drug use - as a meaningful way of life for lower class youth. The perceptions of drug users will vary with the context in which they are seen; studies among street users provide a very different picture to that seen in treatment agencies or jails.

The notion of drug use as a meaningful way of life for unemployed lower class youth has had a significant impact on drug research. The career concept was taken up in the 1980s by British researchers who were examining the place of the heroin lifestyle amongst unemployed youth in Britain at the time (Auld, Dorn et al. 1986; Gilman 1988; Parker, Bakx et al. 1988; Cousins and Bentall 1989). Similar to the United States, researchers found that a lifestyle deeply enmeshed in illegal drug use provided a

meaningful existence for British youth in areas of high unemployment (Unell 1987). Thus, the concept of career was used in two ways. On the one hand, it illustrated the heroin lifestyle as an alternative professional occupation. On the other hand, it described the movement into the social world of illegal drug use - a 'drug career' that begins with the introduction to illegal drugs, the attainment of skills and the norms of the illegal drug world for both dabblers and more frequent users, then to the experience of the minority — dependence, and finally 'coming off' and 'staying off' (Pearson 1987).

Most of this research was conducted on males by males. Two studies have applied the career concept to women's drug use. In describing the experience of women heroin users in the United States Rosenbaum (1981) expanded Becker's career notion. Like Becker, she used a career analogy to describe the women's introduction into the social worlds where illegal drug use was common, the process of becoming and managing 'addiction' and at the same time 'taking care of the business' of work and family, principally children. But whereas Becker used the career metaphor to illustrate the process of *entering* into the illegal drug world and gaining the skills necessary in that world, Rosenbaum went on to examine the career options available to the women after some years of dependence on heroin - moving into crime or going 'straight'. She noted that the longer a woman remained in the 'heroin life', the more her occupational opportunities begin to narrow and she argued that the alternatives available to women wanting to move away from a heroin dependent lifestyle were limited, frequently resulting in recidivism, a return to the 'deviant world'. Furthermore, even the traditional female occupation of wife and mother can be closed off as women become more enmeshed in a world of addiction and crime; children are often taken away, or placed with relatives when women are incarcerated or enter treatment. The problems of 'coming off' and 'staying off' were later noted in the 1980s UK heroin studies but Rosenbaum draws particular attention to the problems faced by women, aged by heroin use, who faced differential societal attitudes for males and females who have transgressed. In the area of interpersonal and sexual relations, women faced additional difficulties. They alone are seen as 'damaged goods': 'the man is seen as having temporarily transgressed, whereas the woman is defined as having permanently fallen' (Rosenbaum 1981:132).

The career metaphor was not used again to illustrate women's drug use until over a decade later when Taylor (1993) applied it when describing a community of female illegal drug users in Glasgow. Like the men in the other drug 'career' studies in Britain, these women lived in working class areas with little chance of meaningful employment. Taylor argues that a 'drug career' provided the women with the opportunity to gain a 'set of skills which were sought after, and provided them with self-esteem, a social identity, and status'. Unlike other working class women, drug dealing women had high incomes. As Taylor notes, 'the likelihood of their finding a career with similar benefits in the formal economy was extremely slight' (p. 153).

So, like their male counterparts, for women, a drug career provided an attractive alternative to other options available in a high unemployment working class area. But unlike men, most female drug users, like many other women, have two careers: one in the public sphere (a drug career) and one in the domestic sphere (p. 154).

Taylor argues that the career explanation of drug use has seldom been applied to illustrate women's drug using experiences possibly because women have this alternative occupation as mothers in the domestic sphere (p. 155). Taylor notes that most women in her study were capable, loving and responsible mothers. But, like many other women, despite their expectations to the contrary, they found that 'the experience of motherhood did not fulfil their needs' (p. 156). Many found child rearing stressful, tiring and depressing. In these circumstances other women have often turned to licit drugs (benzodiazepines or alcohol), but for these women, the illegal drug scene provided the 'means of enabling them to meet the demands and cope with the stresses encountered in the family arena, and to cope with the guilt which arises from women's self-blame for their lack of contentment' (pp. 157–8).

However, unemployed youth, both male and female, are the minority of people who use illegal drugs (see Chapters 3 and 4 for a detailed discussion of identifying illegal drug users). Most users are formally employed (although their drug use is hidden from colleagues in the licit economy). The occupational career model is not relevant in explaining their drug use. Other theories are needed to help us to understand the wider phenomenon.

## **THE PLEASURE MODEL**

A quite different model explaining drug use is presented by O'Malley and Mugford (1991). This model recognises that the use of psychotropic drugs for non-medical purposes has been known since human societies were formed (Plant 1981; Siegal 1989). Furthermore, it is thought that the majority of drug users (of both alcohol and illegal drugs) use their drug of choice without developing problems (Plant 1981; Hartnoll, Mitcheson et al. 1985; Kosel and Adams 1986; Mugford 1991).

It has been argued, first by Plant (1981) and later by Mugford that models of drug use such as have been described in the previous sections were developed by researchers and health professionals working with people who experienced problematic drug use. Explanations for these problems rely on what Mugford calls deficit models which have been developed to account for drug use among a minority of the drug using population, that is those who come to official attention at any one time, through the health or law enforcement system. The majority of drug users who exhibit no pathology associated with their drug use are ignored by deficit models (Mugford 1991).

Although psychotropic drugs have been used for recreational and religious purposes for many centuries, there has been an increase in the level of drug use in the twentieth century. A variety of explanations have been presented for this change. Merton (1963) proposes that people have felt the need to retreat from the complexities of modern society through the use of drugs. Mugford and Cohen, however, argue that the increase in drug use is related to the increase in leisure time in modern capitalist society. With the development of a capitalist mode of production, time has come to be distinctly divided between paid work and leisure whereas this clear distinction did not prevail in the pre-industrial agricultural system (Mugford and Cohen 1988). Hence, modern society has come to contain

a complex and possibly contradictory relationship between the production centred ethic which constructs the self through discipline, control, work, 'clock time', deferred gratification and calculative rationality, and a consumption ethic that encourages self expression, leisure, consumer goods and pleasure (Mugford and Cohen 1988).

Increased leisure time has resulted in more consumption of pleasurable commodities. Drugs can be thought of as one such commodity. The discourse of pleasure in relation to drugs is common among users. But it has been 'systematically silenced by the pathology discourse, which ignores the idea of pleasure and, or treats it as part of the problem (only weak people seek such pleasures)' (O'Malley and Mugford 1991). The pleasure model provides an explanation for much recreational drug use, both legal and illegal which occurs at parties and other leisure activities. Drugs, including alcohol and coffee, provide rapid transitions in mood states that parallel and 'symbolise the rapid transitions between work and leisure, production and commodities'.

This model, however, does not deny the reality of dependent use. Rather, it recognises that people in treatment constitute the minority of users and it sets out to develop a model to help understand drug use by the majority.

## **TAKING GENDER INTO ACCOUNT**

Much of the above research and theorising was done predominantly among males. Except for the 'career model' research by Rosenbaum (1981) and Taylor (1993), there has been little attempt to move beyond a gender-blind approach which assumes that the theories constitute an explanation for generic human experience. In this section, I examine two distinct perspectives, namely pathology and the pleasure model, taking gender into account. I examine only one aspect within the the pathology perspective, that is, the disease model. While a gender analysis of other types of drug treatment within the pathology perspective, such as methadone maintenance and cognitive behavioural therapy, can probably lead to improved methods in these types of treatment, the analysis in this thesis is restricted to the disease model part of the pathology perspective because I was principally interested in the beginning development of drug theory in relation to gender. A consideration of gender in cognitive behavioural therapy and methadone maintenance treatment is a subject for further research. In this section, I explore the application of the disease and pleasure models to those people who do not fit the dominant male model, namely women and some groups of men.

The disease model (and the mode of treatment arising both in 12 step groups and therapeutic communities) contains several particular problems for women. One of the first steps in disease model treatment common in both these organisations is the application of confrontational techniques to break down the denial of chemical dependency and 'admit powerlessness' over the drug. Confrontational strategies are meant to overcome the tendency to 'minimise the problem and maintain an appearance of control' - a tendency which has been more common among men than women (Reed 1985). The confrontational technique was effective in the development of the disease model therapy and among self-help groups such as AA and NA where the majority of clients were men. But it is less appropriate and may even be harmful to women (Copeland 1994). The reasons are twofold. The first relates to social construction of gender and the second to shame.

### ***Social construction of gender***

Because of the different traditional sex-specific norms for boys and girls, more women than men are likely to be threatened and feel uncomfortable with confrontation and conflict. Unlike men, who have grown up subject to a culture which encourages men towards toughness, competition and overt expressions of anger and disagreement, the majority of women have not developed a tough outer shell and tend to be more ready to consider and discuss what others see as their past errors. A part of the confrontational technique's verbal conflict, often loud and aggressive, which many women experience as abuse, can be counterproductive as it provokes a shutdown of feelings and obstructs exploration of the reasons for past behaviour. Although women's responses to confrontation vary considerably and are influenced by ethnic background, age, social class and a variety of other social and demographic characteristics, nevertheless, confrontation is generally less effective among women than men.

Given the varieties of masculinities, there will be some men, like many women, who withdraw when faced with the tough and competitive interaction typical of dominant masculinity (see Carrigan, Connell and Lee (1985) and Connell (1987) for a discussion of types of masculinity). For many of these men, the confrontational method will also be counterproductive. The confrontational method was developed in working with male alcoholics, and as such, addresses characteristics of hegemonic masculinity in relation to addiction - toughness and denial of their problems with alcohol and/or other drugs. As Reed notes (1985:26), 'the need to feel in control and to minimise anxiety means that many men must stoutly deny their difficulties with chemical dependency'. Confrontation is one of the first steps used in breaking down that denial. But for some men, confrontation techniques are alienating and not effective as their type of masculinity is at odds with the dominant male culture.

### ***Shame***

The issues of shame are also complicated by gender. One attraction of the disease model is that it offers those suffering from chemical dependency an explanation for their past shameful behaviour. Much of the responsibility and moral condemnation for past addictive behaviour is removed, explained by their disease of addiction.

However, sexual shame is not addressed by the disease model. Given the cultural mores that have evaluated women's sexual activity negatively and held women responsible for acts of sexual violence against them, sexual shaming is more likely to be a problem experienced by women than men. In addition, a greater proportion of chemically dependent women than men have experienced sexual activities that are seen as shameful and secretive - be it incest, prostitution or sexual assault. These sexual shame issues have not normally been dealt with in AA and NA. Because of the additional feelings of shame and guilt arising out of sexual experiences, many of these women have found the need for a more supportive environment so that they can deal with sexual assault issues as well as their chemical dependency problems (Young 1990). For some women, forming women-only self-help groups both within AA and outside (such as Women for Sobriety) has been one way of addressing some of these difficulties. For others, it was choosing women only treatment services (Copeland and Hall 1992).

In addition, for some chemically dependent men, abuse and sexual assault are issues in recovery. Since women have put sexual issues on the agenda in drug treatment, these men have gradually emerged and raised the same issues for men in recovery (Broom 1995). There is some evidence to suggest that while more than half of the women in drug treatment have been subject to sexual assault, possibly up to a third of men in treatment have similar problems (Bammer 1993). Like women, failure to address sexual abuse issues in recovery is probably contributing to the relapse rate among men (Rohsenow, Corbett et al. 1988).

Despite these drawbacks, the disease model remains an important theoretical perspective which provides an attractive model for recovery for many people with chemical dependency. The continuing popularity of AA and NA demonstrates the attractiveness of the disease model. In a recent national survey of Australian women in drug treatment, nearly half (42%) of women reported that self help groups such as 12-step programs (for example, AA and NA) were totally positive experiences (Swift and Copeland 1996:215). But a notion of the gendered history of the model helps in modifying how it is applied so that it can be of use to more people.

Similarly, I would argue that the pleasure model provides an additional useful perspective for understanding drug use, but incorporating gender into the model points to some of the complexities in application. Research among women who use illegal drugs supports the pleasure model. In an ethnographic study of female injecting drug users in Glasgow, Taylor (1993:149) found that the most common factors instigating the beginning use of illegal drugs among women were curiosity, excitement and pleasurable effects of the drug. But pleasure-seeking may have some gender specific implications and it can place some women in conflict. Adolescents, both male and female, seek new and exciting experiences. But for many young women, this desire for excitement and pleasure conflicts with the socially desirable expectation of remaining 'a nice girl' (Fox 1977), 'a good woman' (Matthews 1984). Adolescent activities that offer excitement and exploration to adulthood - sexual activities such as being a flirt, sexually active or sexually promiscuous, or being intoxicated with drugs (both legal and illegal) pose the risk for girls being labelled 'slags' or 'sluts' (Lees 1993). For boys, there are no such dangers and conflicts. As Lees notes (1993:30) there is no equivalent to 'slag' in the vocabulary of derogatory terms available to be directed at boys. On the contrary, boys boast about their sexual conquests and holding their liquor or being drunk. For them, being sexually active and drunk are signs of achievement of hegemonic masculinity. Many girls are aware of their contradictory position and adopt different strategies to deal with the double standard, much of which involves curtailing their behaviour to avoid the dreaded label of slag (Lees 1993). Thus, women's pleasure seeking is more complicated and can become subverted and hidden (Ettorre 1989; 1992: 28).

In contrast, some young women, when engaging exciting activities, are surprised when others see them as 'sluts' or even 'not nice girls' for what they see as normal youthful fun which is not denigrated when boys do it. These encounters represent some of their first experiences with the double standard and limits that the norms of femininity placed on girls trying illegal, exciting exploratory experiences. In Chapter 7, I examine these issues in greater detail when reviewing the stigma and sexuality issues raised by the women I interviewed.



## SUMMARY AND CONCLUSION

The models discussed in this chapter have been useful in a variety of ways. The pleasure model helps explain why young people try illegal drugs and the 'career' model suggests why others (such as the unemployed) continue to use illegal drugs. For some people who have problems with their drug use, the disease theory of addiction provides a means of recovery from past shameful behaviour, a discourse for dealing with past problems, and an approach to present and future threats relating to drug use. But accepting the disease theory of addiction means accepting lifelong abstinence from the problem drug(s), and for many, abstinence is not a reasonable solution to their drug problem. Cognitive behavioural therapies, such as controlled drinking programs, offer a treatment for drug dependency which does not involve abstinence. Similarly, drug substitution programs such as methadone maintenance can be the answer for many of those to whom abstinence is not an acceptable option. The majority of people in treatment for opioid dependence in Australia are in methadone programs (Commonwealth Department of Human Services and Health 1995:28). For some people in drug substitution programs, a pleasure discourse remains part of their drug use. Multiple models of drug use overlap and co-exist because they are applicable to and provide a discourse for different sections of the drug community.

In this chapter, I explored the construction of gender in two perspectives of drug use, namely the pathology and the pleasure model. I examined only one aspect within the pathology perspective, that is, the disease model. Clearly, examining the impact of gender in other treatment modalities within the pathology model could be fruitful.

Nevertheless, as I have shown, the taken-for-granted assumptions about gender norms of the times are embedded in these models. Examining gender in models of drug use and treatment suggests that many of the theories that have been developed incorporate a hegemonic male perspective and so hinder application for many women and some men.

Thus, a gender analysis of drug treatment and theory helps in uncovering the social construction of knowledge in the drug field and leads to improved treatment options for both men and women. In this research, I have not examined the differing impacts of gender in all drug treatment modalities but have taken some specific examples to demonstrate how the social constructions of gender are encompassed in drug theories and the treatment options arising out of the theories.

## CHAPTER 3: METHODOLOGY AND SAMPLES

Data for this thesis were collected by two methodological approaches, one quantitative and the other mainly qualitative. In this chapter, I outline the quantitative approach that has been used with multiple indicators to estimate trends in illegal drug use, both internationally and in Australia. I also describe how the qualitative study, based upon interviews conducted with women using illegal drugs, adds to the picture obtained from the quantitative data. I describe the rationale and design for each study and compare the samples of women collected by the two methods.

### THE DEVELOPMENT OF DRUG INDICATORS AS A MEASURE OF ILLEGAL DRUG USE

Developing methods to monitor the levels and nature of illegal drug use have proved to be much more difficult than measuring the use of legal drugs such as tobacco and alcohol. The current paradigm is to use data from several complementary sources to provide indicators of the level and nature of illegal drug use. This solution, used first in North America and the United Kingdom employed data from: (1) population surveys, such as in the US, the National Household Survey on Drug Abuse, and other surveys like the High School Seniors Survey; (2) health agency records such as the Drug Abuse Warning Network (DAWN) and the Client Oriented Data Acquisition Process (CODAP); (3) extrapolation techniques from addicts' death and other sources (Hartnoll, Mitcheson et al. 1985); and (4) law enforcement records. Other supplementary sources that have been used are trends in Hepatitis B infection. Such procedures lead to the development of multiple indicators for the use of illegal drugs. For a more detailed review of the rationale and literature associated with the development of multiple indicators and the advantages and disadvantages for the different indicators, see Appendix A.

Since the relative success of multiple indicators as an epidemiological method of assessing illegal drug use, the method has been gradually adopted in other countries and regions (Rootman 1988; Hartnoll 1994; Centre for Drug Research 1995). However, although all of the drug indicator data sets consist of mainly male samples, the degree to which gender has been considered in developing indicators of illegal drug use is variable. Survey data, DAWN reports and CODAP all include information on sex, age and race/ethnicity. Thus, estimates of both incidence and prevalence by sex have been available from survey data. But surveys are of limited value in assessing use of illegal drugs such as heroin (see Appendix A for details). Other sources, such as DAWN and CODAP data have proven to be more useful measures of the incidence of heroin use (see Appendix A). However, the gender of the drug users was of little interest in the early work on illegal drug indicators and much more attention was paid to ethnicity and age in the analysis of the data. For example, an ageing of the heroin using population between the late 1970s and the early 1980 was noted from DAWN and CODAP data, indicating that most heroin users in the US were initiated into heroin use between the mid 1960s and 1970s (Kosel and Adams 1986:30). However, there was negligible interest in the sex distribution of the samples.

Estimates of the prevalence of heroin use paid even less attention to the sex distribution of their samples. Prevalence estimates of the numbers of heroin users in the general

population invariably ignored the sex distribution of the sample from which the estimates were drawn. The best work on the estimates of the prevalence of heroin use provided figures which took some account of age groupings in estimating prevalence and then also included some information on the characteristics of the sample from which the prevalence rates were calculated. For example, Hartnoll and co-workers (1985) estimated that the rate per 1000 population aged 16-44 years in some areas in London rose from 3 per thousand in 1977 to at least 14.2 per thousand in 1983. After calculating these rates, they discuss the characteristics of the sample. Among other things, they note that the 'male to female ratio was about 1.8/1' which was a higher proportion of females compared to previous studies (Hartnoll, Mitcheson et al. 1985:204).

The trend in the last two decades in drug indicator research, as in drug research generally, has been to pay more attention to the sex distribution of the samples. Thus, it would be rare for present drug indicator research to neglect to report of the distribution of the sexes in their data and some drug trend forecasters have begun analysing male and female data separately. For example, the US National Institute of Justice, in a 1991 Drug Use Forecasting report analysed the data separately for male and female arrestees (National Institute of Justice 1991).

However, discussions of the significance of the distribution are rare. The few occasions when researchers have noted changes in the sex distribution are instructive. For example, in a recent National Institute on Drug Abuse (NIDA) (1996) publication on epidemiological trends in drug abuse, the researchers note that the gender gap altered when the data set in Texas 'lost the predominantly male criminal justice clients' (p. 40).

In a more thorough analysis of age and gender characteristics, Strang and Taylor (1997), while examining the data from the UK Home Office Addicts Index from 1980 to 1995, found that there have been major changes in the 'characteristics of new addicts notified' over that period 'to which attention has not previously been shown'. They observe that while the heroin epidemic of the early 1980s was characterised by an increase in young users, the epidemic of the 1990s shows a quite different picture. They found that a 'sharply increasing male predominance is evident from 1990 onwards, the last year of the constant gender ratio of 2.5:1 which had been seen throughout the 1980s. This rises to more than 3:1 in 1992 and reaches a peak gender ratio of 3.5: by 1993' (Strang 1997:46). They express concern that the surveillance system had 'failed so fundamentally to recognise the different characteristics of the new heroin epidemic' and note that 'it was not for the lack of data or investments in the machinery of data collection'. Rather, they suggest, that 'our new data-collecting power now needs to be accompanied by at least some investment in time for academic study of these collected data, so that information may be translated into knowledge and so that science may better serve the policy-making process' (Strang 1997:47). This is a message that the burgeoning international research using multiple drug indicators could heed. The increase in drug indicator research around the world is encouraging, but care must be taken to move beyond a simple compilation of statistics to detailed analysis.

## MEASURING ILLEGAL DRUG USE IN AUSTRALIA

Before 1985, the two most common methods of monitoring drug use in Australia were drug arrests and drug-related deaths (Wardlaw 1986). The National Campaign against Drug Abuse changed the situation considerably. Among the first developments were national population studies on the characteristics and level of drug use in Australia. The first survey was conducted in 1985 and four more national household studies followed in 1988, 1991, 1993 and 1995. All the national household surveys collected data on both men and women aged 14 years or more.

However, while population surveys provide a fairly good indication of trends for legal drugs and cannabis, they are not as useful in detecting patterns of use for less commonly used illegal drugs such as heroin and cocaine (Nicholas Clarke and Associates 1987:8; Jones 1993:53-54; Makkai and McAllister 1994:45-46). The Australian national population surveys indicate that 1 to 2 per cent of people report ever using heroin and less than 1 per cent report using heroin in the last 12 months. Under 3 per cent of the population had ever tried cocaine, ecstasy, designer drugs and inhalants and less than 1 per cent were currently using these drugs. Similarly, under 3 per cent reported ever injecting drugs (Commonwealth Department of Health and Family Services 1996:2).

In the late 1980s efforts began to develop multiple drug indicators to improve estimates of the incidence, prevalence and character of illegal drug use in Australia. The first attempt was the ACT Drug Indicators Project, that was set up in 1987 as a three year pilot project. The Project was a localised community project designed to test the multiple drug indicator methodologies developed internationally in a small Australian community with a population of just over a quarter of a million people. One aim was essentially the development and verification of multiple indicators (Wardlaw 1989:346). The project consisted of two parts. The first was a compilation of drug use indicators from analyses of routine statistics provided by a wide range of health, welfare and law enforcement agencies, (hereafter referred to as the Agency Study). The second, complementary research project involved the use of qualitative research techniques to gather information on drug use and dealing by those who elude official statistics (Wardlaw 1989:349).

In addition to the ACT Project, the *Illicit Drug Situation Report* was implemented nationally in 1989, based mainly upon health and law enforcement records. The health data consisted of both quantitative and qualitative data, which were supplied by each jurisdiction through the National Drug Abuse Data System. The data included information on the number of clients admitted to residential treatment agencies over the collection period and the main drug(s) associated with their admission; qualitative reports from 'key informants' having direct contact with drug users in non-residential agencies who provided estimates of the current levels of use and availability of illicit drugs; and the number of telephone enquires regarding illicit drugs to specified health and welfare agencies.

Law enforcement data were provided by the Australian Bureau of Criminal Intelligence (ABCI) in reports each six months titled '*Major Drugs Report*', for the Australasian Police Ministers' Council. These reports included data from police in all jurisdictions, the Australian Customs Service, and the National Crimes Authority. Data included

numbers of arrests and seizures for illicit drugs, and police estimates of availability of drugs (Wardlaw 1994:3).

The 1989 *Illicit Drug Situation Report* included only aggregated data, which masked trends in specific localities. To remedy this deficiency, the reporting system was altered in 1990 to include regional reporting (Wardlaw 1994:3). However, a number of problems remained, including the anecdotal nature of the reporting system due to the failure to recruit knowledgeable and representative key informants. This led to criticism of the reliability of the information (Wardlaw 1994). The system was disbanded in 1992.

In 1995, a revised Illicit Drug Reporting System (IDRS) was trialed. The revised system aimed to provide 'an early warning indicator of the use, availability and related health problems of the main drug categories so that responses could be implemented before significant problems developed' (Hando, O'Brien et al. 1997:1). Early warning indicators were defined as data available within 12 months of collection. Following the trial, it was recommended that a revised Illicit Drug Reporting System be implemented consisting of the following elements:

- 1) Key informant interviews with health, law enforcement, outreach and research professionals;
- 2) A survey of Intravenous Drug Users (IDU) who represent a sentinel population of illicit drug users;
- 3) Analysis of early warning indicators from surveys, health and law enforcement data (Hando, O'Brien et al. 1997:54).

This proposal was endorsed at the Ministerial Council on Drug Strategy in July 1996 (Australian Bureau of Criminal Intelligence 1996:178), and implementation is now proceeding. However, there may be some difficulties with implementing some parts of the scheme, in particular some data from law enforcement agencies. During the trial period of the IDRS it was hoped to analyse data on drug arrest by drug type but this did not occur because of inconsistencies in data derived from different places (Hando, O'Brien et al. 1997:44). The current plan is to collect a 'standardised set of drug statistics' from law enforcement agencies in the future IDRS to allow compilation of national data on drug arrests by drug type. (Hando, O'Brien et al. 1997:44). Although the trial IDRS had no opportunity to analyse data on drug arrests, these were the type of data, that were collected and analysed by the ACT Drug Indicators Project, and which showed some interesting gender differences.

This thesis examines the comparative value of health and law enforcement sources as indicators of men's and women's drug use. The Agency Study of the ACT Drug Indicators Project assessed a range of established sources as indicators of illegal drug use - hospital emergency room drug mentions, ambulance data, hepatitis B notifications, coronial examination of drug related deaths, hospital morbidity data, calls to drug information and counselling telephone services, and use of needle exchanges, none of which provided satisfactory data for regular monitoring of illegal drug use in the ACT community (Stevens 1989). Only the monthly reports collected from drug treatment and the law enforcement/criminal justice agencies provided sufficient data on which to

base estimates of patterns of drug use, and the characteristics of illegal drug users in the ACT population (see Appendix B for a copy of the ACT Drug Indicators monthly reports forms: (1) the police data form, and (2) the client record form). The data contained in these reports became the main component of the agency study of the project and the study design is described in detail in the next section.

### **The ACT Drug Indicators Project**

The ACT Drug Indicators Project collected data from all the major drug treatment and criminal justice agencies in the local area, which includes both the Australian Capital Territory (ACT) and the nearby city of Queanbeyan. Agencies from Queanbeyan were included in the study because, although Queanbeyan is in New South Wales, the city is adjacent to the ACT border and functions, in part, as a suburban area of the ACT. The population of the region (ACT and Queanbeyan) was estimated at 273 300 at 30 June 1988 (Australian Bureau of Statistics 1988:7).

The agencies which contributed data for the Project include both government and non government organisations and are listed in Table 3.1. The health sector of government is represented by the Alcohol and Drug Service of the ACT Department of Health and Community Care<sup>7</sup> which has three units offering services to drug users. The Detoxification Unit (at Woden Valley Hospital)<sup>8</sup> runs a 10–13 bed unit. Admission involves a stay of up to two weeks. The Hospital Unit, at the time, ran the only methadone program in the ACT and also conducts an outpatient counselling service. The Community Unit also offers outpatient counselling.

The non-government sector consists of a number of agencies and includes therapeutic communities (Karralika, Mancare and WHOS), one detoxification unit using non-drug natural methods (Crisis Detoxification Centre), and a drop-in and counselling service run by the Drug Referral and Information Service (DRIC). Toora is a single women's refuge which provides services for drug affected women in association with their Women's Addiction Recovery Service (Morgain 1994). In addition, there are a number of halfway houses which opened during the course of the project.

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<sup>7</sup> Now called ACT Department of Health and Community Care, it was known as the ACT Health Authority at the beginning of the study.

<sup>8</sup> Now called The Canberra Hospital.

**Table 3-1: Number of Agency Reports September 1987—December 1989**

Agency	Reports per agency	
	Females	Males
Alcohol and Drug Service		
– Hospital Unit <sup>a</sup>	75	127
– Detoxification Unit <sup>a</sup>	89	226
– Community Unit <sup>a</sup>	13	56
Queanbeyan Alcohol and Drug Service	29	45
Crisis Detoxification Centre (CDC)	97	315
Drug Referral and Information Centre (DRIC)	30	113
ADFACT Karralika Therapeutic Community	34	102
Toora <sup>b</sup>	159	0
We Help Ourselves (WHOS) <sup>c</sup>	18	25
Mancare <sup>d</sup>	0	30
ADFACT Halfway House (Kambah) <sup>e</sup>	0	21
DRIC Halfway House <sup>f</sup>	3	9
ACT/Queanbeyan Corrective Services	17	84
Australian Federal Police (ACT)	108	372
NSW Police (Queanbeyan)	56	240
Totals Reports	728	1765

<sup>a</sup> Reported from 1 March 1988.

<sup>b</sup> Reported from 1 April 1988.

<sup>c</sup> Reports to September 1988 when the ACT section of WHOS closed.

<sup>d</sup> Reports from 1 March 1989.

<sup>e</sup> Reports from 1 March 1989.

<sup>f</sup> Reports from 1 June 1989.

Note: Ten reports are excluded from this analysis; 2 transsexuals and 8 reports where sex was not recorded.

The unit of analysis in the ACT Drug Indicators project was a person who becomes a client, not the number of people seen by an agency. Thus drop-in visits, such as those at DRIC, were not included in this data set if the client did not provide enough information for a unique identifier.<sup>9</sup> Because people can be seen by several different agencies, the Project needed a unique identifier to determine when the same individual was presenting at different agencies (including both the health and criminal justice agencies) and so only count that person once. Over the two year period of the study, 80 per cent of people were registered only once to any agency. Thus, the sample reported here consisted of 1837 individuals although 2593 reports were received.

The criminal justice sector is represented by the corrective service agencies in the ACT and Queanbeyan; the Queanbeyan Police (NSW Police) and the ACT Drug Squad (Australian Federal Police), who both report on the drug arrests for their respective areas. Queanbeyan was also represented by the Queanbeyan Alcohol and Drug Service, a government agency, which provides an outpatient counselling service.

### Methods

Data were collected on:

- a) all people arrested on a drug charge;
- b) all new clients presenting to a drug treatment agency with an illegal drug problem or reporting use of an illegal drug in the last month (note that the project did not collect

<sup>9</sup> The unique identifier was created from the date of birth and 3 letters from the person's name.

data on admissions/contacts where clients reported legal drug problems such as alcohol or tranquillisers but no illegal drug use in the last month. Thus the study under-represented the extent of alcohol use and tranquilliser use); and

- c) new cases to the probation and parole service and/or community services sections of the corrective services agencies with a drug or drug-related charge/offence (drug-related offences were defined as those cases on non-drug charges where the officers either counselled for drug use or referred to a drug treatment agency); plus present clients who reported returning to or beginning drug use.

The data presented in this thesis were collected for the period 1 September 1987 to 31 December 1989. In describing the characteristics and patterns of drug use, the significant differences between women and men were tested using SPSS/PC version 5.0 (Norusis 1992a; 1992b) by the following methods. Nominal and ordinal data were analysed by chi-square tests and Fisher's exact test was used when 2x2 tables had values of less than 5. Continuous variables were analysed by two-tailed t-tests. Regression analysis was used in controlling for dependent variables associated with age at beginning drug use. A significant level of difference was set at  $p < .05$ .

## **THE FIELD STUDY: INTERVIEWING WOMEN USING ILLEGAL DRUGS**

### **Rationale/Aims**

A central purpose of the field study was to gather information to provide a detailed description of women's drug use, and to assess how the social construction of gender, in particular, femininities, are negotiated and constituted among illegal drug users. In undertaking this task, I explored sexuality and stigma issues for the women using illegal drugs. The interviews for this drug research differed from most other drug research in that they contained a section on sexual experiences, including sexual harassment and abuse, and another section on femininity and the stigma associated with women's drug use.

Sexuality issues have become relevant in the study of women and drugs in a number of ways. Research on women in drug treatment has shown high rates of child sexual abuse, ranging from estimates of 47 per cent of women in Australian drug treatment services (Copeland and Hall 1992) to as high as 74 per cent among women in American inpatient drug treatment programs (Rohsenow, Corbett et al. 1988). These rates are much higher than those in the general community which have been estimated at 20 per cent of Australian women (Fleming 1997) and ranging between 16 and 62 per cent in American populations (Russell 1986).

Stigma related to drug use appears to be different for men and women. Women's alcohol and illegal drug use is regarded with greater concern, disapproval and alarm than men's use of the same recreational drugs (Fillmore 1984; Erickson and Murray 1989). Public perceptions associating alcohol use with sexual promiscuity in women have added to the stigmatisation of alcoholic women and may result in their physical and sexual victimisation (Blume 1991). Prevailing norms of appropriate femininity and masculinity have contributed to a double standard for men's and women's drug use (Broom and Stevens 1991).



Sexual abuse and stigma can both be facets of gender relations for many women who use illegal drugs. The purpose of gathering information on sexuality, femininity and stigma was to explore the ways women who use illegal drugs have negotiated the gender order and the social construction of femininity, and the degree to which the discourses they experience stigmatise women who use illegal drugs, both in the illegal drug worlds and in the wider community.

One aim of the study was to sample a wide range of women who used illegal drugs in a variety of ways, including recreational experimental use, dependent use and those who had given up illegal drugs at the time of interview. In addition to collecting the routine information on drug use as collated in the ACT Drug Indicators Project, the interview also collect additional information not available from the routine data collection via the agencies. For example, the ACT Drug Indicators Project data on age at first use of the major drugs allowed a statistical comparison between men and women. The interviews provide additional quantitative data as well as qualitative data on how women begin using drugs (both legal and illegal) which included information about the social setting and companions - the process of initiation into drug use. The rich data from the interviews allowed me to examine the contention that women are generally introduced to drugs by male partners which has been used to explain how gender relations of the wider society are replicated in the social worlds of illegal drug users. Thus, the interview study was descriptive and exploratory, a quite different approach to the epidemiological project in the ACT Drug Indicators study.

## **Method**

The field study was based on 51 interviews with women who were using or had used at least two illegal drugs. The interview questionnaire was semi-structured and was developed after a review of other related drug research instruments and consultation with drug research professionals and workers from a number of drug agencies in the ACT: Toora - a feminist collective providing services to single, drug affected women; Karralika - a therapeutic community which conducts women's groups as part of their treatment program; and ACTIV (otherwise known as the ACT Intravenous League): a self help group for men and women who have been or are presently using illegal drugs. The questions relating to physical and sexual abuse in Part 4 of my questionnaire are similar to those asked by at least one of the agencies as part of their admission procedures. In common with the experience in these agencies, I found that most of the women were pleased at the opportunity to address these issues. For some women, the interview was the first time they had disclosed previous abuse experiences. A few women took the opportunity to vent their feelings about the abuse while others simply glossed over the incident(s), not wanting to describe them in detail. One woman chose to terminate the interview after two hours but sought to come back at a later occasion to complete the interview. With any woman who disclosed abuse experiences, I checked whether she had sought help or reported the assault and to whom; and when appropriate, I discussed the range of sexual assault counselling services in the ACT and advised about how these agencies are contacted.

## **Interview Procedures**

Four pilot interviews were conducted in June 1992 with a range of women (feminist, recreational users, ex-user with drug treatment experience, user with experience with self-help user groups) and feedback on the questionnaire was discussed at the completion of each of the pilot interviews. The revised questionnaire (shown at Appendix C) was then used as a guide for interviews which began in July 1992 and were completed in November 1992.

Most women were interviewed in an office at the Australian National University. Those in a treatment program or contacted via a treatment program were interviewed in an office at Karralika. A few women were interviewed in their home or mine.

The interviews were audiotaped and supplemented by notes on the questionnaire form. Three interviews were not fully taped due to equipment problems and notes from the interview form were added to the transcript of the tapes not fully recorded.

## **Recruitment of Women**

Participants were obtained from personal contacts and by using a snowball technique such as described by Granovetter (1974) and Biernacki and Waldorf (1981). Initial contacts were friends and colleagues from my time working on the ACT Drug Indicators Project and at the Australian National University. The initial contacts included the women who participated in the pilot interviews, who then handed on the flyers advertising the study and seeking respondents. The flyer (see Appendix D) advises that participants would be recompensed \$40 for their time at interview.

Payment for respondents has been the subject of debate (Weppner 1977) with Agar (1977) arguing that it is unnecessary and can introduce bias, while others, such as Johnson (1985) and his team taking a different view. Some researchers have repaid their respondents in other ways 'such as appearing in court for them, lending them money or helping them get employment' (Deane 1989). Given that other ACT drug researchers recently had paid \$40 at interviews, my options were limited as a standard seemed to have been set in the ACT which was difficult to ignore. However, along with other researchers (Weppner 1977), I found that once the participants trusted you, they were pleased at the interest in their lives and enjoyed telling their story and sharing their expertise and knowledge.

Other factors such as the characteristics of the interviewer seem to be as relevant in obtaining successful interviews. Erickson and colleagues (1994) observed that the basic and essential interview skills included '(b)eing, attentive, nonjudgemental, knowledgeable about the subject matter (using slang terms, for instance), informal in dress, relaxed in manner, and to inspire trust' as well as 'an ability to be genuinely interested in and caring' about the respondents (1994:90). The trust and confidence in sharing information in the interviews varied, ranging from some women who provided extensive detail to others who limited themselves to the simple facts. The interviews ranged in time from 45 minutes to 3-4 hours.

The snowball sampling involved inviting interviewees to pass on the flyer to friends in their networks. Women who were then interested in participating in the study then

contacted me at one of the advertised phone numbers or called into my office at the University. On first contact, they were advised about the conditions of the interview as in the information sheet at Appendix E and a mutually convenient time and place to meet was arranged.

## **Sample Selection**

The only criteria for entry of women into the study was to have used two or more illegal drugs. All participants were over 18 years of age except for a few respondents between 16 and 18 years of age who were accepted in the study as they were living independently, that is, not living with parents or a guardian. Respondents were sought through a range of sources including both women who had been in treatment and those who had not in treatment in order to sample a range of experience.

## **Confidentiality**

No identifying information was collected. Except for initial contacts, I had no identifying information about the participants - I only knew their first names and had no way of contacting them. They contacted me seeking interview and they were encouraged to remain on a first name basis and use pseudonyms if they wished. None of the participants chose to use a pseudonym with me, but, on transcribing the tapes, each woman was given a pseudonym and any tape recording which contained possible identifying information was wiped after transcription. When reporting direct quotes from the women, a pseudonym is used. In the text, I use upper cases for my questions and the women's responses are in lower case.

## **Ethics**

The study was approved by the Ethics in Human Experimentation Committee of the Australian National University. Informed consent as to the interview conditions was achieved by the information provided by the information sheet. In addition, on first contact and at the beginning of the interview, I stressed to each woman that she should not feel obliged to answer all of the questions and that she could choose to withdraw from the interview at any stage, or she could simply choose not to answer some questions. Remuneration for the interview was paid before the interview began.

## **Data analysis**

The text of the interviews was analysed using a computer software program for text analysis called Non-numerical Unstructured Data Indexing, Searching and Theorising (NUD.IST). Computer assisted analysis of qualitative data has developed rapidly over the last decade and offers a number of advantages not previously available (Fielding and Lee 1991). The NUD.IST program provides a computer assisted method of coding and retrieving text which is superior to the manual methods of the past (Richards 1990).

## **Characteristics of the sample**

The women who came for interview presented a great variety of experiences. Amongst the teenagers in the sample were young women who were experimental users and others

who had had periods of dependency on heroin. Two of the women under 20 were in a drug treatment program. The women ranged in age from 16 to 40 years with an average age of 24.8 years ( $sd=6.6$ ). The age distribution is shown in the following table and compares the characteristics of women in the field study with the women in the Agency study of the ACT Drug Indicators Project (DIP).

**Table 3-2: Age distribution**

Age groups (years)	No. (n=51)	Per cent	DIP Per cent
Under 20 yrs	15	29	24
20-24 yrs	13	25	26
25-29 yrs	11	22	26
30-34 yrs	7	14	13
36-40 yrs	5	10	6
40 + yrs	0	0	5

## SUMMARY

This thesis examines gender in different perspectives. The quantitative data collected in the Agency study of the ACT Drug Indicators Project is examined in Chapter 4 as a way of testing the merits of these types of data sets as indicators of both men's and women's drug use. The gender analysis presents another way of addressing the strengths and weakness of sources that are used as indicators of incidence and prevalence of illegal drug use in the wider community. The interviews provided a wealth of information on the women's experience of drug use and allowed an exploration of gender relations for women who use illegal drugs.

## CHAPTER 4: MEASURING WOMEN'S ILLEGAL DRUG USE: GENDERING EPIDEMIOLOGICAL DRUG STUDIES<sup>10</sup>

In this chapter, I examine data collected for the agency study of ACT Drug Indicators Project (DIP) as a way of comparing the indicators of illegal drug use for men and women. As described in the previous chapter, the agency study collected data on admissions to drug treatment and corrective service agencies and all arrests for drug offences in the ACT area. I argue that in developing epidemiological methods of monitoring illegal drug use, we must pay explicit attention to gender to avoid the trap of the past of developing a research method that is supposedly gender neutral but actually tells us principally about men's use and can misrepresent the picture of women's drug use. In this chapter I address the question of the adequacy of data on drug treatment and arrest rates as tools in describing women's illegal drug use.

In the first section I compare the demographic characteristics of the men and women, as well as the characteristics of their criminal behaviour, both criminal record and current charges. The second section compares the reports provided by the different agencies on the major types of drugs; I first examine the data collected from the drug treatment and corrective service agencies, then the data from the police on arrests for drug offences. The analysis of the police data includes an examination of the gendered nature of the law enforcement system. The third section considers the gendered nature of the drug treatment agencies and addresses the question of how closely the sex ratios in drug treatment approximate the proportions of men and women in the general community who use illegal drugs. I conclude by noting that the arrest data minimises and distorts the picture of women's illegal drug use, and argue further that the gendered social construction of arrest data arises out of taken-for-granted assumptions about appropriate behaviour for men and women in the general community which are reflected in a gendered law enforcement culture and police responses to women's drug use.

### DEMOGRAPHICS

In the sample of 1837 individuals, 536 (29 per cent) were women. Only 19.8 per cent of those arrested by the police were women, whereas in the drug treatment agencies, 34.3 per cent of clients were female. The possible reasons for the lower proportion of women in the police sample are complex and are examined in detail below in a later section of this chapter.

Both the law enforcement agencies and the drug treatment and welfare agencies, collected a core set of data, but each type of agency also collected data related to their own particular concerns. For example, all agencies in the study collected basic information on employment status, but the drug treatment and welfare agencies collected more detail on occupational status than did the police. On the other hand, the police provided detailed information on the type of drug charges in relation to the type of drug, and they were the only source of information on the seizure of illegal drugs.

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<sup>10</sup> This chapter has been revised and expanded from a chapter entitled "Measuring Illicit Drug Use among Women" Pp. 21–39 in D. Broom (ed.) *Double Bind* (1994) [#374]. The previous version was co-authored with Grant Wardlaw who instigated the ACT Drug Indicators Project and his contribution to this chapter is acknowledged where appropriate in the text of this version.

There were several differences in the demographic characteristics of the women and the men which mirror differences found in the general ACT community (Australian Bureau of Statistics 1988). As in the general community, a smaller proportion of women than men were in paid employment and proportionally more women than men had children living with them (ACT Community and Health Service 1989). These findings are not unexpected and demonstrate that there are similarities between of the social lives of illegal drug users and of those in the wider society. Nevertheless, although the gender patterns were similar to those in the general community, there were large differences in the workforce status of the DIP sample compared to the wider community. Approximately two thirds of the general community is in paid employment compared to approximately one third of the DIP sample (ACT Community and Health Service 1989; Stevens 1989).

The following sections address gender differences in the demographic findings for ACT Drug Indicators sample in detail.

## Occupation

There was a significant difference in the employment status of men and women. Women were less likely to be in a paid job than men; 18 per cent of the women and 38 per cent of the men were in paid labour force ( $\chi^2 = 194.4$ , d.f. = 6,  $p < 0.0001$ ). A greater proportion of the women were at home looking after children and family or on a pension such as the supporting parent benefit. More women than men reported that they were students (see Table 4.1 and Appendix F, Table F1).<sup>11</sup>

**Table 4-1: Employment Status**

	% of Females (n=501)	% of Males (n=1197)
Employed in paid labour force	18	38
Not in paid labour force		
– Home duties	11	0.6
– Pensions (sickness/supporting parent)	19	10
– Student	7	2
– Unemployed	31	32
– Details not known (police data)	13	17

Amongst those employed, there is a gendering of occupational categories similar to that which occurs in the general community (ACT Community and Health Service 1989). For women, the two most common occupational categories were sales/personal service (32 per cent) and clerk (28 per cent), but for men the most common occupations were labourer (37 per cent) and tradesperson (33.3 per cent) (see Appendix F, Table F2). Nevertheless, in making these generalisations, it is important to not lose sight of the occupational diversity among this group of illegal drug users; 25 (3 per cent) of the men and 5 (2 per cent) of the women were managers or administrators; there were 27 men

<sup>11</sup> All tables in this chapter and Appendix F are taken from data collected from the ACT Drug Indicators Project for the period September 1987 to December 1989 inclusive. This information is not reproduced in the table headings. The tables in this chapter are abstracted from more detailed information in Appendix F tables. .

and 20 women in professional occupations, and in para-professional occupations there were 18 men and 18 women.

## Children

There was no significant difference in the proportion of men and women who had children under 18 years of age (about 40 per cent), but significantly more women (37 per cent) than men (25 per cent) had children living with them ( $\chi^2 = 22.5$ , d.f. = 3,  $p < 0.0001$ ). This difference reflects the family patterns of the general community (ACT Community and Health Service 1989).

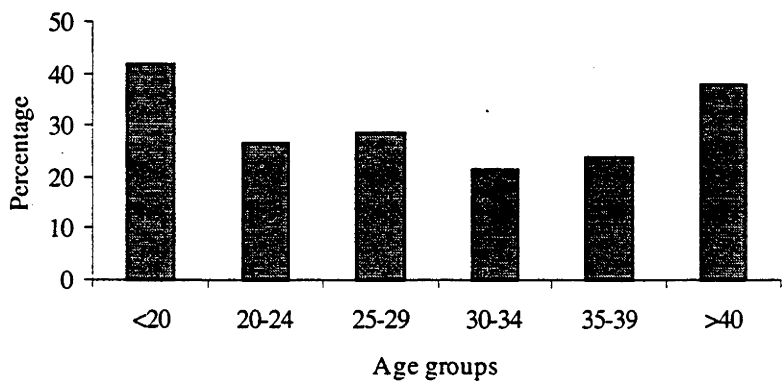
## Age

Women were on average significantly younger than men ( $t=2.98$ ,  $p=0.003$ ) (women  $\bar{x} = 25.4$  years (SD 7.2), men  $\bar{x} = 26.5$  (SD 6.5)). A number of studies of Australian treatment agencies have noted that the women in treatment are younger than the men (Swensen 1983; Chen, Mattick et al. 1993; Hall, Chen et al. 1993).

Amongst the ACT Drug Indicators sample, there was a wide age range. For women, ages ranged from 13 to 58 years, with a modal age of 18 years, and a median of 24 years. The lowest proportions of women were in the 20–39 age groups (see Figure 1 and Appendix F, Table F3). Women constituted 42 per cent of those under 20 years. But for women in the major child-bearing and child-rearing ages (20–39), the proportion varied from 22 to 29 per cent. At first glance, it seems surprising that the proportion of men and women in the study group would vary at different ages. One explanation appears to lie in the significance of motherhood for women users. The proportion of women rises again in the over 40s age group, and it is likely, therefore, that the apparent significant drop in the population of women in the ACT Drug Indicators sample in the 20–39 age group is not a reflection of a significant drop in the population of women users, but in the proportion of that population in the drug treatment or criminal justice systems.

Two factors support this hypothesis. Women with dependent children must find childcare if they want to attend most treatment programs. Women with children in their care are much less likely to use drug treatment agencies, particularly residential services which have no facilities for children (Reed 1987). In the ACT, the creation of the family program at the Karralika therapeutic community in June 1989 has demonstrated this point. The proportion of women has increased since the introduction of the family program - from 29 per cent in 1989 to 43 per cent in 1991. The staff at Karralika attribute this to their ability to accommodate women with their children through the family program (Blatch 1991).

Figure 4-1: Females as a percentage of the total sample, by age



The other significant factor is the stigma associated with illegal drug use, particularly for mothers. Jude Byrne, then co-ordinator of ACTIV League, suggests that some women with children are reluctant to contact drug treatment agencies because they fear losing their children to welfare agencies (*Canberra Times* May 10, 1992, p.18).

The significant increase in the proportion of women seeking treatment since the creation of the family program at Karralika suggests strongly that many women may seek to stop or reduce their drug use when they have children. If the treatment systems in general supported them, in the manner of the Karralika program, it is likely that women would come to constitute a higher proportion of the 20-39 age group.

Marital status

Although the majority of both men and women were single (61% and 54% respectively), a greater proportion of men were single whereas a greater proportion of the women were married or living together in a permanent relationship ( $\chi^2 = 16.2$ , d.f. = 4,  $p=0.003$ ) (see Table 4.2).

Table 4-2: Marital status

	% Females (n=460) %	% Males (n=959) %
Never married	54	61
Married/living together	30	25
Separated	9	8
Divorced	5	6
Widowed	2	0.2

An examination by age group showed that this difference in marital status is only significant among those aged 20–29 years ( $\chi^2 = 19.2$ , d.f. = 4,  $p<0.001$ ). The explanation for these differences is not clear. Again the differences occur in the child-bearing and rearing years. In the older age groups - over 35 years - similar proportions of men and women were married but proportionally more women were separated, divorced or widowed. In the ACT, in all age groups, there was a greater proportion of single men.



It is possible that some men do not report their *de facto* relationships whereas women, especially women with children, are more likely to report even a tenuous *de facto* relationship. In addition, the sex differences in marital status may also be a reflection of self selection into treatment. Single men who do not have the support of a wife may get into more trouble with illegal drug use than married men.

## Accommodation

The majority of both men and women reported living in a house or flat (57% of men, 54% of women) with fewer than 10 per cent living in a group house (see Table 4.3). The next most common type of accommodation reported by women is living temporarily with friends or siblings, living in the street and in cars, refuges and shelters. Such arrangements are the least secure residential circumstances (Kieboom, Stevens et al. 1990). For men, living in the parental home was the second most common form of accommodation.

**Table 4-3: Type of accommodation**

	% Females (n=493)	% Males (n=1141)
Flat or house	54	57
Refuge/shelter/itinerant	22	11
Parental home	13	19
Group house or flat	9	9
Low cost accommodation	2	3
Other <sup>a</sup>	1	2

a Includes long term drug rehabilitation, hostels, remand centre or jail.

Although by no means conclusive, these findings contribute to the impression that a significant proportion of these women do not feel comfortable or safe in the parental home. They may reflect in part the high rate of incest reported from women in drug treatment agencies (Wilsnack 1984; Hurley 1991; Russell and Wilsnack 1991; Copeland and Hall 1992; Wilsnack, Vogeltanz et al. 1997).

## Crime

Over three-quarters of the men (79%) and just over half of the women (52%) had a criminal record. Similarly, over half of the men (62%) but less than 40 per cent of the women were facing a current charge (see Appendix F, Table F4). Clearly, the legal system has more impact on men than women in bringing their illegal drug use to official attention. This is also shown in the different pathways into treatment for men and women and is discussed in more detail in the section below on gendering of drug treatment services.

The heavily skewed sex ratios in crime rates, including drug-related offences, have been a subject of debate in the criminology field for some decades (Pollak 1950; Mukherjee and Fitzgerald 1981; Anleu 1991). Both in Australia and overseas, women constitute only a small minority of those convicted of criminal offences. For example, in Australia in 1988–89, the ratio of men to women convicted for property offences such as 'break,

enter and steal' was 12 to 1. For juveniles it was 16 to 1.<sup>12</sup> Similarly, women constitute only a small proportion of the prison population, amounting to 5.4 per cent in 1990 (Easteal 1992). Various theories about and explanations for the differences in sex ratios in crime statistics and the impact on drug arrests data are discussed below in the section on drug arrests.

## **DRUG REPORTS AS INDICATORS OF ILLEGAL DRUG USE**

One of the aims of the ACT Drug Indicators Project was to evaluate the different methodologies for estimating drug use trends and determine which methods provided the best estimates. This section examines and compares men and women, using data from different agencies to indicate patterns of use for the major illegal drugs in the ACT. It is divided into two parts. The first compares the data for men and women from drug treatment and corrective service agencies while the second considers the police data on arrests. Finally, I present an analysis of the gendered nature of the law enforcement system in relation to arrests for drug offences.

### **Drug Treatment and Corrective Services Data**

Two types of data were collected from the drug treatment agencies: the primary/presenting drug problem(s) and reports on recent drug use. The primary/presenting drug problem data indicates which drug(s) prompt people to seek help. Traditionally, information on presenting drug problems is collected by drug treatment agencies. Since 1985, in New South Wales, non-government residential drug treatment agencies have reported on the presenting (both primary and secondary) drug problems to the New South Wales Drug and Alcohol Directorate (Didcott 1988; Darke, Kelaher et al. 1996). Since the instigation in 1990 of the one-day national census on clients in Australian drug and alcohol treatment agencies, national trend data on the primary/presenting drug problems have been available (Torres, Mattick et al. 1995). These types of data indicate some of the health consequences of drug misuse and have been used as indicators in trends in illegal drug use. The ACT Drug Indicators Project collected information on both primary drug problems and recent drug use from the drug treatment agencies, and information on recent drug use from the corrective services agencies.

#### ***ACT Drug Treatment Data: Problem Drug(s)***

Generally only one or two drugs were nominated as problem drug(s). Cases where more than two drugs were nominated were coded as a poly-drug problem, but comparatively few clients were so categorised.<sup>13</sup> As Table 4.4 shows, alcohol is most likely to cause the most problems for both men and women, closely followed by heroin. These two substances are associated with most of the admissions to drug treatment agencies in the rest of Australia as well in the ACT (Torres, Mattick et al. 1995). There was no significant difference between the proportion of men and women reporting a problem with heroin. However, proportionally more men than women reported having problems with alcohol. This is not surprising given that in Australia, as elsewhere,

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<sup>12</sup> These ratios calculated from figures on crimes cleared in Australia (see Mukherjee and Dagger 1990:80).

<sup>13</sup> Note that this refers to problem, not use.

community surveys have shown that more females than males are non drinkers (McAllister, Moore et al. 1991:46), and a higher proportion of males than females are high risk drinkers (Commonwealth Department of Health, Housing and Community Services 1992:14).

Proportionally more women (18%) than men (10%) reported having a poly-drug problem. That finding confirms the observation that women are more likely than men to use prescription drugs, and therefore to mix prescription, licit and illicit drugs. Similarly, a higher proportion of women (9%) than men (2%) presented with problems with benzodiazepines and other tranquillisers. On the other hand, more men than women reported a problem with cannabis use. This could be related to the fact that a much larger proportion of men are arrested for cannabis offences than women (discussed in detail in the section below on drug arrests). Problems which bring people to treatment agencies are related to legal as well as health and social difficulties. It is not uncommon, in Australia and elsewhere, for people who are before the courts for a drug charge to attend drug treatment agencies in order to demonstrate that they are managing their drug problem and so obtain a more lenient sentence or determination. In an analysis of US drug treatment data, Greene suggests that a proportion of those in drug treatment programs who report cannabis as a primary problem have 'no problems directly related to their drug use but are referred because of concerns others (law enforcement or school authorities) have about their drug use' (1975:407).

**Table 4-4: Reporting of problem drug(s) to treatment agencies, by type of drug**

	%Females (n=365)	%Males <sup>a</sup> (n=663)	P values
Alcohol	35	44	0.003
Heroin	34	35	n.s. <sup>c</sup>
Polydrug	18	10	0.002
Benzodiazepines/other tranquillisers	9	2	<0.0001
Cannabis	7	11	0.02
Amphetamines	7	6	n.s.
Methadone and other opioids	2	3	0.04
Over the counter/other drugs	0.8	0.3	0.02 <sup>b</sup>
Hallucinogens	0.8	0.6	n.s. <sup>b</sup>
Cocaine	0	0.6	n.s. <sup>b</sup>

a For the purposes of calculating these percentages two transsexuals and the missing data were excluded from the analysis. Because some clients report more than one presenting drug problem, the percentages total more than 100.

b Only a small number of people reported problems with these drugs, so Fisher's exact test was used to calculate significant differences.

c n.s. = not significant.

### **Recent Drug Use**

A different picture emerges from the reports on recent drug use which were provided from both the drug treatment agencies and the corrective services agencies. The aim of the project was to collect information on all drugs used in the month prior to the report. All of the agencies were able to provide this except for the Alcohol and Drug Service which already had a data collection system recording drug use in the last three months. The Alcohol and Drug Service altered their data collection system during 1988 to provide uniformity but some of the data collected on recent drug use during 1988 refers to drugs used in the last three months.

The patterns of recent drug use bear little relation to the presenting drug problem. Among this sample of illegal drug users, cannabis was the drug used most commonly by both men and women, followed by alcohol (see Table 4.5 and Appendix F, Table F5). For women, the next most commonly used drug was some kind of tranquilliser (such as the benzodiazepines) while for men, it was heroin.

**Table 4-5: Recent drug use**

	% Females (n = 409)	% Males (n = 783)	P values
Cannabis	74	81	0.005
Alcohol	72	75	n.s.
Benzodiazepines/other tranx	51	33	<0.0001
Heroin	49	53	n.s.
Amphetamines/other stimulants <sup>a</sup>	41	39	n.s.
Cocaine	17	17	n.s.
Over the counter/other drugs <sup>b</sup>	17	10	0.001
Methadone and other opiates	16	15	n.s.
Hallucinogens	12	14	n.s.
Total Number of Drug Reports <sup>c</sup>	1424	2637	
Number of Persons	409	783	

a Includes four cases of ecstasy.

b Includes inhalants, laxatives, anti-depressants, slimming tablets, polaramine and kava.

c Total drug reports exceed the number of persons reported because of clients reporting multiple drug use. Percentages are calculated on the number of persons reported.

Over half of the women (51%) and a third of the men (33%) had used benzodiazepines or another tranquilliser recently. It has been well recognised that, for a variety of reasons, women are more likely to use minor tranquillisers such as benzodiazepines (and in the past, barbiturates) than men (Cooperstock 1978; Mant, Broom et al. 1983). However, more recent work has shown that age is a better predictor of benzodiazepine use with the proportion of people who use benzodiazepines increasing with age (Hancock, Walsh et al. 1992). In a community survey conducted in Newcastle in 1987–8, Hancock and co-workers (1992), found that less than five per cent of men between 25 and 34 reported using benzodiazepines in the last three months, whereas among the ACT Drug Indicators group, more than thirty per cent of men had used tranquillisers in the last month. So although the ACT Drug Indicators study supports the finding that women are more likely than men to use benzodiazepines, it indicates that the level of benzodiazepine use is much higher among these illegal drug users, both men and women, than in the general community.

Recent research has shown that both in Australia and overseas, benzodiazepines are widely used among injecting drug users (IDUs) (Klee, Faugier et al. 1990; Darke 1994). In Australia in the 1990s, the prevalence of benzodiazepine use has been reported to range upwards from a third of IDUs, among both primary heroin and amphetamine users (Darke, Hall et al. 1992; 1994). IDUs report that tranquillisers, obtained either legally or illegally, are used either as a substitute for heroin when opioids are unobtainable or to enhance the effect of other drugs (McDonald, Stevens et al. 1993). An Australian study of heroin users in 1994 found that heroin was the drug most commonly used in conjunction with benzodiazepines, and that the main reason given by IDUs for continued use of benzodiazepines was management of heroin withdrawal. In

contrast, the main reason for *first* using benzodiazepines was to induce or increase intoxication (Darke, Kelaher et al. 1996).

In the ACT study, men were significantly more likely than women to use cannabis and women were more likely than men to use tranquillisers and over-the-counter drugs. Similarly, a population survey of adults in Western Australia found that a greater proportion of females reported ever using slimming tablets, tranquillisers and minor analgesics whereas proportionally more males had ever used marijuana, hallucinogens, solvents and tobacco (Blaze-Temple, Binns et al. 1988:77). NCADA National Household surveys show that more men than women use cannabis (Jones 1993:51; Makkai 1994:34). In this ACT sample of illegal drug users, there was no significant sex difference in recent use of hallucinogens, heroin and other opioids, alcohol, amphetamines or cocaine.

A striking finding is that polydrug use is quite common for both men and women. In the 1–3 months prior to admission, 409 women reported using 1424 drugs, which yields an average 3.5 drugs per woman. For men, the average was 3.4 drugs per person. Most people would come to agencies with a specific problem, such as heroin; but these data show that the majority who present with a heroin problem are frequently using alcohol and cannabis as well.

The reasons for these patterns are complex. In the late 1980s, users reported that over the previous ten years illicit drugs had become harder to get. When illicit drugs are difficult to obtain, people use alcohol as a substitute and get prescriptions for benzodiazepines. That is, when they cannot use illicit drugs they use legal drugs. It is important to note that this is a treatment population, not recreational users; so if they cannot get one drug, they are likely to seek out something else which may explain why polydrug use is so common in this population. However, they may not be using all these drugs once. The information gathered was on drugs used in the last month; some people may use one drug on one day and a different drug on another.

The 'other stimulants' category included three people who reported use of methylenedioxymethamphetamines (MDMA) otherwise known as ecstasy. This information provided indications of changes in illegal drug use in the community. Street talk and anecdotal reports from agency staff indicated that ecstasy was available in Canberra around the middle of 1987. However no clients attending drug treatment or corrective service agencies reported using ecstasy until 1988.

### **Mode of Use**

Drug treatment and corrective service agencies also collect information on mode of use. Given the concern about HIV transmission via injection, it is important to monitor the injecting habits of drug users. In Australia injection is the most common mode of use for heroin for all users. Over 90 per cent of both men and women who use heroin report injecting it. In this treatment population, injection is also the most common mode of use for amphetamines, although amphetamines are taken in other ways (see Table 4.6 and Appendix F, Table F6). An examination of method of use by gender shows that in this treatment population, men are more likely than women to inject both amphetamines and cocaine. For amphetamines although a greater proportion of men than women inject, the ratio is reversed for oral use. For cocaine, there are similar patterns (see

Table 4.7 and Appendix F, Table F7). Proportionally more men inject whereas women are more likely than men to snort cocaine.

**Table 4-6: Amphetamines: mode of use**

	% Females (n=154)	% Males (n=290)	P values
Inject	60	70	0.02
Oral	32	20	0.004
Nasal	26	25	n.s.
Smoke	1	7	0.004

**Table 4-7: Cocaine: mode of use**

	% Females (n=60)	% Males (n=118)	P values
Nasal	67	50	0.03
Inject	41	61	0.008
Smoke	2	7	<sup>a</sup> n.s.
Oral	0	2	<sup>a</sup> n.s.

Monitoring mode of use is important as injection of an illegal drug presents a significant risk for transmission of HIV and hepatitis B and C (Wodak and Crofts 1994; Carruthers, Loxley et al. 1997) and changing modes of administration from injecting to other forms of use is one plank in the control strategy for these diseases (Wodak 1997).

**Police Data - Arrests for Drug Offences**

I now turn to a consideration of the data from police sources. Of the 643 individuals arrested for drug offences over the period of the study, only 127 (20%) were women. Furthermore, the arrests by drug type show some interesting differences between men and women (see Table 4.8). Cannabis-related offences were the most common offence for both sexes, but among the men the proportion was higher (81% for the men versus 76% for the women<sup>14</sup>). There is nearly a 5:1 ratio of men to women for cannabis-related offences. With the so called ‘hard drugs’, the differences are not so great; nearly a 3:1 ratio of men to women for heroin arrests and a ratio of 3.5:1 for amphetamine-related arrests. Thus, the high proportion of cannabis arrests among men increases the proportion of males in drug arrests overall and is the most significant factor, numerically speaking, in the large number of male arrests compared with female.

<sup>14</sup> This difference was not statistically significant among the group arrested.

**Table 4-8: Drug Arrests by Drug Type (column per cent)**

	Males (n=516)		Females (n=127)	
	No.	%	No.	%
Cannabis	420	81	96	76
Heroin/other opiates	58	11	20	16
Amphetamines	57	11	17	13
Cocaine	5	1	0	0
Benzodiazepines	4	1	1	1
Hallucinogens	2	0.4	0	0

a Percentages are calculated using the number of persons arrested as the base. Consequently, percentages total more than 100 because, on occasions, people are charged with offences involving more than one type of drug at one arrest.

Similar contrasts have been noted in convictions for drug offences in Canada. In an examination of Canadian drug convictions from 1980 to 1985, Erickson (1990) found comparable disparities in that convictions for cannabis offences were overwhelmingly male, with 11.1 men convicted for each woman. Heroin convictions, on the other hand, displayed smaller gender differences with 3.5 men convicted for each woman. The large gender differences for cannabis arrests was also noted in a study in South Australia which found that 'far fewer females appeared in police statistics than should have been the case if these figures were representative of actual consumers' (Sarre 1992:104).

Community surveys indicate that men and women use marijuana in much more equal proportions than is indicated by the police statistics. For example, in the 1991 Australian National Household Survey, 13 per cent of women and 17 per cent of men reported using marijuana in the last year (Commonwealth Department of Health, Housing and Community Services 1992:33-34). In Canada, high school surveys in 1987 found that 18.7 per cent of males were using cannabis compared to 13.2 per cent of females. Among adults, for the same year, '12.3% of men compared to 6.8% of women, reported using cannabis in the last 12 months' (Erickson and Watson 1990:253).

There are a number of hypotheses which could explain the large disparity between the sexes in cannabis arrest rates. Cannabis arrests are often opportunistic.<sup>15</sup> That is, charges for the use and possession of cannabis arise out of arrests for other offences. People come to the attention of the police for drunk-driving, or offensive behaviour, for example, and they are then found to be in possession of cannabis. Because men come to police attention more than women for traffic offences, disruptive and aggressive acts and other offences, they are more likely to be arrested as a consequence for cannabis offences. Women are much less likely than men to display unruly behaviour and hence to get caught.

Some support for the 'opportunistic cannabis arrest hypothesis' comes from a study by the Advisory Committee on Illicit Drugs. Analysis of court records in Queensland showed that over 40 per cent of cannabis offences were detected by chance while police were 'responding to complaints, engaged in routine patrols, making unrelated enquires

<sup>15</sup> My thanks to Grant Wardlaw for suggesting this theory.

or engaged in other tasks’ (Criminal Justice Commission 1993:72). A comparison of those apprehended with people reporting use of cannabis in the 1991 NCADA household survey, showed that although the apprehended group were similar to the user group in age and marital profile, they were more likely to be *male*, unemployed or unskilled workers, indicating that both gender and class influence the likelihood of arrest for cannabis offences.

To test the opportunistic arrest hypothesis, the ACT Drug Indicators Project collected data on the arresting unit, examining whether the arrest was made by the drug squad or another police unit. Drug charges that occurred incidentally to an arrest for another offence would probably be made by another unit - for example, the traffic or burglary division. In the ACT area, just over half of the arrests for drug offences (51%) were initiated by the drug squad. This suggests that nearly half of the drug charges may have occurred incidentally to arrests for other offences.

If the type of police unit attending a drug arrest is correlated with the type of drug involved, the following patterns emerge. For amphetamine related offences, three quarters of the arrests of women are by the drug squad whereas for males about half are by the drug squad. But for cannabis, the majority of both male and female arrests are made by units other than the drug squad (see Table 4.9). Thus, other units are responsible for most cannabis-related arrests, which, in turn, constitute the bulk of the arrests of males. However, the drug squad is responsible for the majority of the heroin-related arrests for both males and females and also the majority of female amphetamine-related arrests.

**Table 4-9: Drug-related arrests: type of drug and arresting unit**

Arrest unit	Cannabis		Amphetamines		Heroin	
	Male (n=472)	Female (n=115)	Male (n=69)	Female (n=23)	Male (n=95)	Female (n=36)
	%	%	%	%	%	%
Drug Squad	44	47	48	74	84	89
Both Drug and other unit	1.5	3	7	9	1	0
Other Unit	55	50	45	17	15	11

Figures on past criminal records provide some information on the sex ratio in past arrests, thus indicating the different opportunities for opportunistic cannabis arrests. According to these data, there are significant differences between men and women in all arrest categories except in the ‘robbery’, ‘break and enter’ and ‘other’ categories (see Table 4.10 and Appendix F, Table 8). The largest sex difference for arrests occurs in the ‘drink driving’ category. For men, the highest proportion of offences was for drug offences (51%), break and enter (50%) and drink-driving categories (39%). This supports the notion that many cannabis arrests are incidental to apprehension for other offences such as drink-driving and break and enter.



**Table 4-10: Prior Criminal Record, by gender and type of offence <sup>a</sup>**

	% Males (n=821)	% Females <sup>a</sup> (n=231)	P values
Drug offences	51	50	n.s.
Offences against the person (e.g. assault, sexual assault, homicide)	25	14	0.0005
Robbery and extortion	17	13	n.s.
Break and enter (inc. fraud and other theft)	50	41	0.02
Prostitution offences (inc. soliciting, living on earnings)	4	11	<0.0001
Property damage (e.g. malicious damage, arson)	18	9	0.0008
Offences against good order (e.g. offensive behaviour, resist arrest)	27	17	0.001
Drink driving offences	39	14	<0.0001
Other <sup>b</sup>	12	16	n.s.
Unknown type	3	1	n.s.

a Because some people reported more than one prior offence, the percentages total more than 100.

b Includes motor vehicle and traffic offences, failure to appear, under age on licensed premises, vagrancy, drunk and disorderly, and uncontrollable.

Another explanation of the sex differences in drug arrests arises from the 'chivalry hypothesis' which was proposed as a way of explaining the small proportion of women in the official crime statistics (Pollak 1950; Haskell 1970). According to Pollak (1950:2), 'it is part of our culture that women should be protected by men', thus both officers of the law and men in general are reluctant to report and punish women for their crimes. Similarly, Haskell and Yablonsky claim that:

When a man is in the company of a female, chivalry dictates that he assume responsibility for what occurs. If the couple is apprehended fleeing ..., the male is likely to testify that his girlfriend ... played no part in the crime. This is also often true when a couple is apprehended for drug possession (1970:61).

Chivalry, however, is part of a more complex concept of paternalism (Moulds 1980), in which females are seen 'to be weaker, less responsible, and less dangerous than males and they are thought to require greater protection' (Datesman and Scarpitti 1980:314).

For more than two decades, there has been considerable dispute over both the evidence for and the alternative interpretations presented in support of the 'chivalry thesis' (Anderson 1976; Scutt 1979; Douglas 1987; Edwards 1989:167; Steury 1990). Edwards (1989) has criticised the empirical nature of the earlier work arguing that the concepts require a more thorough analysis and that the subtle biases in the law need further examination. What has emerged from these discussions is that, notwithstanding the language of equality enshrined in the law, sexism in the law still prevails. Although research has shown that the criminal justice system may sometimes favour women (Moulds 1980, Steury, 1990), at other times it functions to their disadvantage (Anderson 1976; Scutt 1979; Hancock 1980; Easta 1993:145). The nature of the sexism in the criminal justice system is complex, and justice varies for both men and women depending on a number of social characteristics, such as class, race, gender and age (Carlen 1987; 1988; Edwards 1989; Naffine 1990).

Punishment for women is influenced by the behaviour and characteristics of the woman and also by the type of offence. Women who conform to a supposedly feminine stereotype (for example, quiet, co-operative, respectable) are less likely to be charged and punished than women who are loud, argumentative, aggressive, thus violating the

standards of 'good' womanhood. Although recent research indicates that the 'lenient' treatment for women in the courts is principally a result of women committing less serious crimes than men (Steury and Frank 1990), Kruttschnitt (1982) has shown that 'disreputable' women who were first offenders were given more severe sentences than 'respectable' women with a criminal record. In short, different women receive different types of punishment (Naffine 1990).

Of more interest for the present study are the decisions made by police to warn or charge a suspected offender. Police have considerable discretion in whether or not to lay charges. This is particularly so regarding drug offences in Australia, where the policy is to target traffickers rather than users. Nevertheless, two-thirds of drug offences are for use or possession (Wardlaw 1986; Stevens 1989:36 Table 20).

Some evidence of police discretion is contained in an American study by Visser (1983) who reported on 785 encounters between police and suspects. Female suspects who displayed 'appropriate gender behaviors and characteristics' were less likely to be arrested than women who deviated from 'stereotypic gender expectations'. However, drug offences were excluded from this study.

The different rates of drug arrests for men and women may be explicable in terms of two interacting stereotypes, held equally by the police and the community in general. These are stereotypes of women and the behaviour, expressed through chivalry and stereotypes regarding different drugs and their users. The rates of arrest for women using cannabis arrests for women could be affected by notions of chivalry/paternalism among police officers. Women who come to police attention for using or possessing cannabis but who display appropriate 'feminine' characteristics may be warned rather than arrested. These women have 'strayed' (come to police attention by their cannabis use) but they are not 'bad'. Provided they maintain the impression of that they are good women who have strayed (e.g. that they have no prior record and they adhere to the standards of 'good' womanhood), they can be treated with leniency.

Women arrested for heroin and amphetamine-related offences are seen in quite a different light because of the drug associated with their apprehension. Heroin and to a lesser extent amphetamines are seen as 'hard' drugs which carry with them the identity as addict. Miller (1991) and others have argued that this identity is total: nothing else about the person matters (Hatty 1993). Attention is focussed on the stigmatised attribute which acquires a 'master status' (Becker 1963). The individual who acquires a 'master status trait' be it drug addict, prostitute, or juvenile delinquent, finds that this label dominates all other personal characteristics; 'good athlete', 'good dancer', and the like are subordinated to or negated by this trait, which is immediately seen to be most central to the 'actual' identity of the individual (Page 1984:11). Whatever their demeanour, women who use 'hard' drugs are likely to be labelled by their 'master status' of addict and so are likely to be regarded by many police officers as not deserving the 'chivalry' extended to conformist women who use a 'soft' drug like cannabis.

For women, the highest proportion of arrests were for drug offences and break and enter offences. The incidental cannabis hypothesis applies to women as well as men when they are involved in more serious crimes such as break and enter, fraud and theft.

However, women do not get arrested to the same extent as men for drink-driving offences and they also have a lower rate of cannabis arrests. These findings make sense in view of an amended chivalry hypothesis. Women may come to police attention in the course of their regular patrols; if they are apprehended for minor offences including cannabis possession they are less likely than men to be arrested if they conform to the feminine stereotype. This reduces the female cannabis arrests and arrests for minor offences. However, the woman apprehended in more serious offences such as robbery and theft can not slide into the category of 'good woman' no matter what her demeanor. Like the 'addict', she acquires a 'master status trait', that of 'serious offender'. Thus the police are less likely to turn a blind eye to the drug offences that are discovered when women are apprehended for more serious crimes.

In conclusion, it is clear that although there is some support for the incidental cannabis arrest hypothesis in these data, it should be remembered that all human behaviour - including arrests in all categories - is mediated by expectations of gender appropriate behaviour. Because human behaviour is so complex, it is likely that both factors (the amended chivalry hypothesis and the incidental cannabis arrest hypothesis) have an effect on the cannabis arrests rates for men and women. Whatever the full explanation, it is clear that the police data exaggerate and distort the gender differences in drug use. Drug arrests appear to be mediated by gender in particular ways which make drug arrests of limited value as an indicator of drug use, and an unreliable indicator of sex differences of use.

## **GENDERING OF DRUG TREATMENT SERVICES**

Compared to arrest data, information collected from drug treatment and corrective service agencies seems at first sight to provide a better measure of women's drug use. It could be argued, however, that women are over-represented in drug treatment data. In mainstream medical services, women generally constitute the majority of clients. Nathanson (1975) and others have argued that because of their 'feminine role' women have a greater propensity than men to seek help for most health problems. Broom (1991:49), however, suggests that the reason women use medical services more than men is as much because they have more health problems as because of a greater propensity to consult. However, the evidence suggesting that women are more likely than men to use drug treatment services is ambiguous.

After a detailed analysis comparing population data with health data, Copeland and Hall (1995) suggest that women are not 'under-represented in alcohol and other drugs treatment in Australia' (1995:12) but they note that the data are insufficient to draw any but tentative conclusions, and in the case of illicit drugs the data sources are even more limited than those on alcohol. Crude estimates of the prevalence of males and females who have ever used illegal drugs such as heroin have been made since 1985 from the Australian National Household Surveys conducted by the National Campaign Against Drug Abuse. The 1985 and 1993 surveys suggest a 2:1 ratio with 2 per cent of males and 1 per cent of females estimated to have ever used heroin. However, the 1991 survey figures suggested an equal ratio with 2 per cent of both males and females reporting to have ever used heroin (Commonwealth Department of Health Housing and Community Services 1992:33).

Population surveys have a number of deficiencies as a tool in making reliable population estimates on rarely used illegal drugs such as heroin. Only small numbers of people in Australia report that they use illegal drugs (Makkai 1994:48), and the 'estimates based on these small numbers are imprecise, resulting in a wide confidence intervals' (Larson and Bammer 1996:495). Copeland and Hall examined confidence intervals in estimates of the male to female ratio for heroin in the 1985 NCADA survey. They note that in a total sample size of 2796 only 2 per cent of males and 1 per cent of females report having ever tried heroin. The 95% confidence intervals around the ratio of men to women ranges from near equality (1.1), to 3.9 times higher among men than women (1995:12). Copeland and Hall attempt to overcome the problems associated with population estimates by using morbidity data on general hospital utilisation associated with opiate use. They compare the ratios of men and women in drug treatment for a primary opiate problem in the Census of Treatment agencies (1.5 males to each female) to the 'ratios in hospital episodes and day beds .... 0.9 and 1.7 respectively' which, they argue, suggests that 'women are over-represented in treatment' for opiate dependency (1995:12). They argue that women with opiate problems may be over-represented in drug treatment, that women who are pregnant are likely to be directed into methadone programs, and the criminal justice system 'may be more likely to direct women using opiates into treatment and men to a custodial sentence' (1995:12).

By contrast, the ACT Drug Indicators data indicate that men are more likely than women to come to treatment through the criminal justice system. Analysis of the source of referral into the treatment agencies showed that the pathways for entry into drug treatment agencies were significantly different for men and women but not in the way posited by Copeland and Hall. Self-referral was the most common mode of entry into treatment for both women and men. Thirty one per cent of men were self-referred but 30 per cent were referred from a legal source such as the court, corrective services, the police or a solicitor. By contrast legal services were the least common mode of referral for women (11 per cent). Women were much more likely than men to be referred by community agencies or family and friends. Less than 10 per cent of men came via community agencies compared to over 20 per cent of the women (see Table 4.11). These differences between men's and women's entry into drug treatment were statistically highly significant (chi-square = 72.3,  $p < 0.001$ ).

**Table 4-11: Referral Source for Drug Treatment Cases**

	% Females (n=407)	% Males (n=776)
Self	28	31
Medical/drug agency	24	22
Community agency	22	8
Family/friend	14	9
Legal sources	11	30

Drug treatment services were developed with predominantly male clientele and staff and so intervention models and treatment organisations that have developed over the last 50 years are gendered services that reflect male values and men's needs (Reed 1987). Consequently, women are less likely than men to use drug treatment services unless the services are modified to suit women's particular needs. The introduction of

childcare services in some residential treatment services has increased the proportion of women in those drug treatment agencies (Blatch 1991). Men still constitute the majority of clients in drug treatment, both for alcohol problems and illegal drug problems, although as Copeland and Hall argue, this is principally a reflection of the greater extent of chemical dependency problems among men. In this ACT sample of illegal drug users, as in other samples of illegal drug users in treatment (Darke, Kelaher et al. 1996), the ratio of men to women was approximately 2 to 1, quite different from the 4 to 1 ratio in the ACT sample on arrests for drug offences.

The types of drug treatment used by men and women reflect social and parenting responsibilities. Although, in the ACT, there is no significant sex difference in the proportion who have previously been in treatment, there is a significant difference in the types of treatment undertaken by women and men. Women were more likely than men to have attended 'outpatient' counselling. More men than women had been in a residential therapeutic community (see Table 4.12). Similarly, the 1992 census of clients of treatment agencies noted that women were more likely to attend outpatient and non-residential care than were men (Chen, Mattick et al. 1993).

**Table 4-12: Types of Previous Treatment**

	<b>% Males (n=431)</b>	<b>% Females (n=215)</b>	<b>P values</b>
Residential therapeutic community	56	46	0.01
Residential detoxification	61	57	ns
Methadone program	32	30	ns
Outpatient counselling	38	47	0.03
Other <sup>a</sup>	10	14	ns

a Includes Alcoholics Anonymous, Narcotics Anonymous, Welfare, Caloola Farm, psychiatrist, and drug treatment from generalist services such as a general hospital.

Clearly, drug treatment agencies as institutions are gendered in particular ways. It is still not clear how far the clients are representative of the proportions of men and women who use illegal drugs.

## CONCLUSIONS

In examining the drug treatment and arrest data, it has become apparent that both data sources are mediated to some extent by gender and reflect different social stereotypes, norms and behaviours for men and women in the community and in the organisations collecting the data. This is not surprising: gender is fundamental to the organisation of many facets of life including work, family life and the law. The gendered nature of work and family life is evident among illegal drug users, with men more often in paid work and women more often having responsibility for children.

The main question of interest in this chapter relates to the adequacy of drug treatment and arrest data as sources for monitoring trends in illegal drug use among women. Both types of data indicate that the official statistics from these sources are gendered but in different ways and to different degrees. Both provide information on illegal drug use which are guides or indicators of the trends in drug use in the wider community - the types of illegal drugs used by men and women and from the drug treatment data, the modes of use. However, the data sets vary considerably as indicators of men's and

women's drug use. The drug treatment data provide a better approximation of the comparative illegal drug use of men and women. Although the data set contains a majority of males, it appears that the information coming from this source presents a reasonable approximation of the different levels of illegal drug use by men and women in the wider community.

By comparison, the arrest data provides a picture which distorts the sex differences in drug use in the wider community. Male cannabis users are disproportionately represented in the arrest data. Previous drug indicator research has warned of 'biases' in law enforcement data which results 'from the processes by which the information comes to the attention of, and is recorded by, authorities' (Rootman 1988:215). However, this warning relates principally to the concern that official statistics on trends from drug arrest and seizures records are as much an indication of the level of police activity and policies as changes in drug use trends (DeFleur 1975; Wardlaw 1986; Stoddart 1988; Hando, O'Brien et al. 1997:44-45). Most of this research has compared the level and type of law enforcement practice to changing levels in arrest and seizures of drugs. The characteristics of illicit drug users apprehended and the extent to which they represent illegal drug users in the wider community have until recently been virtually ignored. There are only a few examples of research that considers which people are represented in drug law enforcement data.

Stoddart (1988) investigated how police decisions influenced the creation of official drug arrest data by an examination of heroin users' reports of arrest encounters in a large city in the Canadian West. He found evidence that, as in other jurisdictions, changes in enforcement policy altered the level of drug arrests over time. In addition, he noted that the decision by police to arrest was related to characteristics of violators, and he concludes that the 'issues of who ...gets assembled into the official statistics' is a 'product of a social judgement made by the police' (1988:249). Women were less likely than men to be targets for heroin arrests, although certain types of women, depending on their appearance and demeanour, were targeted to the same degree as men.

Similarly, in an examination of the masculinity of police culture in relation to drug use and gender Young (1994) argues that in 'the world of policing and drug use' women 'appear and disappear to suit the need' of the masculine police culture. Women 'appear only when a cultural belief in their presence makes it suitable; and they tend to vanish wherever drug-taking has a public persona or is given masculine symbolic relevance' (1994:72).

It is apparent that police practice, to varying degrees, influences the character of arrest data. Both information about the types of drug in arrest statistics (Wardlaw 1986) and the characteristics of those arrested are influenced by police practice. The small proportion of women in the arrest data of the present study compared to the proportions in other types of data indicates a gendered social construction of arrest data, which is a distortion of the sex differences in the wider community. This construction arises out of taken-for-granted assumption about appropriate behaviour for men and women in the general community which are reflected in a gendered law enforcement culture and police responses to women's drug use. For these reasons, arrest data are the least useful in estimating women's drug use. The comparisons of men's and women's cannabis

arrest rates is one example of how the picture of women's illegal drug use is minimised in illegal drug statistics and is an example of the biases that must be considered when comparing what different indicators tell us about illegal drug use.

Arrest data remains, however, an integral component of illegal drug indicators both in Australia and elsewhere. Although, in Australia, the recently instituted Illicit Drug Reporting System does not presently include data on drug arrest by drug type, this was simply because it was not possible at this stage to collate statistics from the different law enforcement agencies that were compatible to compiling national data. Work is proceeding on a 'standardised set of drug statistics' so this type of data can be included in the Illicit Drug Reporting System (Hando, O'Brien et al. 1997:44-45). The present study indicates that these data should be viewed with caution. They are likely to reproduce the biases of past drug research, which developed supposedly gender-neutral research methods, but which tell us principally about men's drug use and misrepresent the nature and characteristics of women's drug use.





## CHAPTER 5: BEGINNING TO USE ALCOHOL AND TOBACCO

Most studies have found that the majority of both male and female addicts are introduced to drugs by a man. This seems to hold true regardless of the type of drug initially used (Hser, Anglin and McGlothlin 1987:37).

The aim of this chapter is to examine gender differences in the process of beginning drug use. As noted in Chapter 1, the prevailing view is that most women are introduced to illegal drugs by men. In keeping with the dominant American ideology, the 'drugs' discussed by Hser and colleagues are only illegal drugs. More recent research, however, has begun to identify differences in ways females begin using different drugs. For example, while replicating the previous findings that male partners were implicated in the move to 'harder substances', Taylor, also noted that females began using 'quasi-licit' drugs 'with and through female friends' (1993:33).

Tobacco and alcohol are also implicated as 'gateway' drugs into illegal drug use (Blaze-Temple and Lo 1992). Most people who use illegal drugs begin in early adolescence with alcohol and tobacco (Kandel 1975; McAllister, Moore et al. 1991:90-91) which are commonly seen as symbols of adulthood, and these two drugs constitute the most common 'routes of entry' into illegal drug use (Kandel and Yamaguchi 1985). For some adolescents, becoming a smoker is one rite of passage into adulthood (Banwell and Young 1993).

In this chapter, I explore gender aspects regarding starting alcohol and tobacco use. While a few researchers have examined the differences between the sexes in age of initiation of the legal drugs (Kandel and Logan 1984; McAllister, Moore et al. 1991), I have found no studies comparing males and females regarding their sources for beginning use of legal drugs. The question is: Do males play a role in introducing women to legal as well as illegal drugs? There are some indications to the contrary. The 1992 Victorian secondary school students survey found that family and peers are the most influential sources for adolescents in initiation of smoking and in the regular use of alcohol (Victorian Department of Health and Community Services 1993). But a number of social factors differed for males and females. Adolescent girls who smoke have been found to be more self confident and socially skilled (e.g. more at ease with their peers, with strangers and with adults) than their non-smoking peers, whereas adolescent boys who smoke tend to lack such qualities (Clayton 1991). These are indications that there are gender aspects in beginning to use legal drugs which influence males and females differently.

In Australia, over the last three decades, a considerable amount of research has been devoted to estimating the prevalence of tobacco smoking (National Health and Medical Research Council 1969; Gray and Hill 1975; 1979; Hill and Gray 1982; 1984; 1988; 1990; 1991; 1993; 1995). NCADA has auspiced more such prevalence studies as well as investigations of the prevalence of other drug use since its inception in 1985. However, research on beginning drug use, in particular, age at first use, was not addressed in detail in Australia until recently. McAllister and his colleagues were among the first to examine patterns of beginning drug use (McAllister, Moore et al. 1991). They examined data from school surveys and the NCADA surveys in the 1980's on the percentage of adolescents using alcohol, tobacco and marijuana at various ages and from this information they attempted to estimate age at first use for these drugs.

The 1991 NCADA National Household Survey was the first national attempt to ascertain directly the age at first use by asking respondents how old they were when they first used alcohol and also tobacco (Commonwealth Department of Human Services and Health 1993). In this chapter, I begin by comparing the findings from the 1991 NCADA National Household Survey on beginning use of tobacco and alcohol with the patterns for an ACT group of illegal drug users. I use the ACT DIP data to compare women and men for age at first use and beginning regular use of alcohol. In the second section, I examine my field interviews for evidence about women's experiences when beginning to use alcohol and tobacco. The third section compares beginning alcohol and tobacco use and describes the social context of the patterns of use described by the women interviewed in the field study.

Appendix G examines some of the technical issues relating to the definition of first use and first regular use.

## BEGINNING ALCOHOL USE - ACT DRUG INDICATORS PROJECT

There was a significant difference between men and women in the age at which they first consumed alcohol ( $t=-3.9$ ,  $p<0.0001$ ). Males began drinking a year younger, on average, than females: at 13.1 years of age ( $sd=3.2$ ) compared to 14.2 years ( $sd=3.8$ ). Table 5.1 shows the proportion of males and females who reported beginning alcohol use at varying ages. Similarly, a comparison of the 1991 and 1993 NCADA national household surveys found that boys first tried alcohol 'a little more than a year, on average, before their female counterparts' (Jones 1993:7).

**Table 5-1: Reported age at first use of alcohol**

Age group	ACT DIP 1988-89			NCADA survey <sup>a</sup> 1991
	% Females (n=232)	% Males (n=399)	%Total (n=631)	% (n=2343)
Under 10 years	7	13	10	4
10-11 years	9	11	10	3
12-13 years	27	25	26	8
14-15 years	29	31	30	19
16-17 years	17	15	16	28
18-19 years	4	4	4	20
20 years and older	7	2	4	17
Total	100	99	100	99
Mean age/first drink	14.2	13.1	13.5	16.3

a Source: Commonwealth Department of Human Services and Health 1993 (p. 36) reports for 1991 and 1993 NCADA National Household Surveys on age when first consumed a full glass of alcohol.

In a study of youth under 25 years of age from New York State, Kandel and Yamaguchi (1985) noted that alcohol use begins early in life. They reported that 20 per cent of their cohort had used alcohol by age 10 and over 50 per cent by age 14. Compared to the Australian data, the proportion of underage drinkers is much smaller in Australia than in New York State. There are methodological problems in comparing this American study with the NCADA data because in the NCADA study first use was recorded as age at first drinking *a full glass of alcohol* and this detail was not required in the Kandel and Yamaguchi study. However, even the proportion of underage drinkers in the ACT Drug

Indicators Project study is not as great as in the Kandel and Yamaguchi study where the same type of question was used (ie. age at first use of alcohol).

Comparing the totals from the ACT Drug Indicators Project with the 1991 NCADA National Household Survey (see last 2 columns in Table 5.1), it is clear that people in treatment for illegal drug use generally commenced drinking alcohol much younger than people in the general population.

Because the NCADA and ACT Drug Indicators Project data sets are made up of people from a wide age range (ACT Drug Indicators Project - 11 to 63 years), the average age for beginning drug use reflects the different beginnings for a number of age cohorts from teenagers to middle aged people. For example, for those under 20 years in the ACT Drug Indicators Project sample, the average age for commencing alcohol use was 12.2 years, but for those 40 years and older it was 15.4 years. Over the last 4 decades, the average age at beginning alcohol use has fallen by approximately a year per decade (Jones 1993:7). Nevertheless, regression analysis controlling for age shows that gender is still a factor in age at beginning alcohol use; females began drinking alcohol on average 1.34 years later than males<sup>16</sup>.

However, analysis by cohort is complicated by the fact that we are not comparing similar groups. The cohort of people who were under 20 at the time of the survey can not by definition include people who began drinking *after* 20 years of age, as the older groups can. For example, as Jones notes of the NCADA Household survey, for the 14-19 year cohort, the calculations for average age at first use understate the age at which this cohort starts drinking, since 1-in-4 have not yet started drinking but are expected to do so in the next five years. This could artificially raise the mean age of beginning to drink alcohol in older cohorts in comparison to the younger cohorts. Jones (1993) overcame this problem in his analysis of the NCADA data by comparing the proportion of people who reported under-age drinking (eg reported having their first drink before they were 18 yrs of age). He found that in each age cohort (eg in each decade) there was an increasing proportion of under-age drinkers, thus providing a more accurate measure of the falling average age of beginning to drink alcohol. While that is a satisfactory technique in a population sample, the same method in the ACT Drug Indicators Project sample is skewed by the fact that the ACT Drug Indicators Project sample is not representative of the population; it is a selected sub-population of people who have experienced problems with their drug use. This population contains a high proportion of people who were under-age drinkers. For those under 20 years of age, 99 per cent reported under-age drinking and in those 40 years and older, 87 per cent reported under-age drinking (see Table 5.2). Thus, although the proportions in all cohorts are higher than in the general population, there is evidence of a secular decline in the age at which drinking began in the ACT Drug Indicators Project population as well.

I tested for the average age at beginning alcohol use for all cohorts for those who began to drink before 18 years of age to allow comparison with the youngest age group. The

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16 The equation is: Age at first use of alcohol = 10.08 + .16(age in years) - 1.34(sex where 1=male, 0=female)

average age falls in each cohort but the differences are much smaller than occurs by comparing the simple average age for beginning to drink alcohol (Table 5.2).

**Table 5-2: ACT Drug Indicators Project: Comparison of mean age of first drink for under-age drinkers and all drinkers**

	Under-age	All drinkers	% first drink under-age
Under 20 years of age	12.18	12.21	99.0
20-29 years	12.85	13.16	97.2
30-39 years	13.69	14.61	94.1
40 yrs and older	13.15	15.36	87.0

**Beginning Regular Use of Alcohol**

For this group of illegal drug users in the Drug Indicators Project, regular drinking began, on average, at 16.3 years (sd=4), about 3 years after first trying alcohol. Among the men, age for beginning regular drinking ranged from 5 to 29 years of age. The most common (modal) ages were 15 and 16 years (54 men at both age groups) and the mean was 16.1 (sd=3.2) - see Table 5.3. For women, however, the age range for beginning to drink alcohol regularly was much wider; 9 to 45 years with a mean of 16.6 (sd=5) and a mode of 15 years. On a t-test there was no significant difference between the men and women in average age at beginning to drink regularly (t=-1.2, p=0.23).

**Table 5-3: Age when began drinking alcohol regularly**

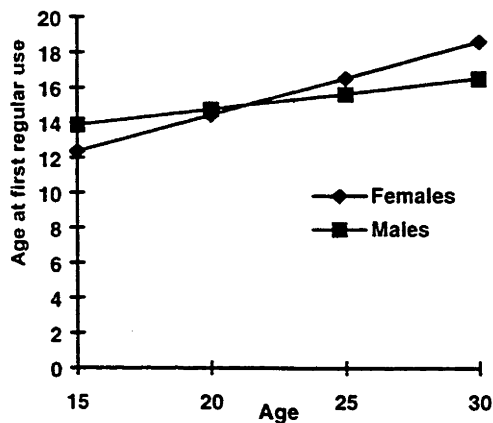
Age group	ACT DIP 1988-89		Field study 1992
	% Males (n=337)	% Females (n=208)	% Females (n=44)
Under 10 years	<1	<1	2
10-11 years	2	3	0
12-13 years	12	18	18
14-15 years	31	28	34
16-17 years	29	23	32
18-19 years	15	11	9
20 years and older	10	16	5
Total	100	100	100
Average age	16.1	16.6	15.4

The differences between the age cohorts hide important differences between the sexes. Those in their teens began drinking regularly on average at 14.1 years of age, and in this group, females tended to begin regular drinking younger than males. Among those in their thirties, the opposite occurs; males reported first drinking regularly on average at least a year earlier than females. A regression analysis controlling for age showed a significant association for both age and sex in relation to age at beginning to drink regularly. I then tested for an interaction effect between sex and age and this is also significant<sup>17</sup>. Figure 5.1 demonstrates the relationship in the equation indicating that

17 The equation is: Age at beginning regular alcohol use = 6.03 + .42(age#) + 5.12(sex) - .24(sex\*age#).

the younger women began drinking regularly at an earlier age than the younger men and a shows a reversal of the sex comparison in the older cohorts.

**Figure 5.1: Comparison by sex of age of beginning regular use of alcohol**



Clearly, the social inhibitions for women drinking are no longer influencing the younger women by the time they become regular drinkers. This indicates a possible change in social mores among the illegal drug users; the older women continued the same patterns as occurred when they first tried alcohol with their patterns of initiation into alcohol use and regular use occurring older than occurs for the boys. The younger women began alcohol use at a later age than the younger men (as occurred with the older women) but began *regular* drinking *before* the young men.

A possible explanation for why young women begin drinking regularly earlier than young men may relate to the social custom of females mixing with older males rather than boyfriends of their own age or younger. Regular drinking, thus, generally begins in a social group of males who are older than the females. However, this does not explain the change over the last two decades as it was only among the younger cohorts that females began drinking regularly at a younger age than the males. Why did the phenomenon occur among the younger women but not the older women? The social custom of girls mixing with older males has been a common practice for many decades. I suggest that the answer lies in the social mores among present day illegal drug users.

From the field study interviews, it became clear that the social stigmas about drunken women are not shared by those in the contemporary illegal drug using culture. Over a third of the women (39%) in the field study commented on the differences that they noted among illegal drug using groups compared to ‘straight’ society. They observed that, in the general society, women who are drunk and out of control are quite often seen as ‘cheap’ and labelled as ‘sluts’ and sexually available. There is no such stigma

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# In this analysis, age was recoded by centering the data. This was necessary because of the multicollinearity problems in the interaction term and the accepted method of solving this problem is to centre the data (Aiken 1991; Jaccard 1990). The recoded value for age with centre is obtained by subtracting the mean from each score as in the following formula: recoded age = age - mean of age

among illegal drug users; to be intoxicated and sexually active does not carry the social denigration applied to women in the 'straight' society.

Illegal drugs users are comfortable with intoxication in both women and men. Among some groups, there is a celebration of drug using and excess. One Canberra group of illegal drug users created a day of celebration 'St Oswald's Day' which centres around the use of intoxicating drugs, both legal (such as alcohol) and illegal (Dance and Mugford 1992) which is reminiscent of the traditional 'Carnival' celebration. Gusfield (1991) has suggested that Carnival, as a festival of excess with its licensed release from many prohibitions on eating, sexuality and social hierarchy, in many countries occurs before and contrasts with the ascetic period of Lent. These two holidays also appear as metaphors for alternating and opposed attitudes towards life (1991:399). It is the Carnival attitude towards life that is embraced by many illegal drug users.

Some young women who mix with illegal drug users, therefore, are partly freed from the prohibitions of the general society regarding women's intoxication. The culture of illegal drug users provides an alternative reference group that celebrates fun and intoxication for women as well as men.

Women generally did not begin drinking regularly after they had begun using illegal drugs (Ellickson and Hays 1991). In the ACT Drug Indicators sample, women first tried cannabis on average at 15.7 years of age but they did not begin drinking regularly until an average age of 16.6 years. So it is likely that the general societal inhibitions about women drinking are no longer informing the choices of the young women by the time they become regular drinkers. At that time these women were generally moving amongst the illegal drug using culture. I address the issues of subculture differences in more detail in Chapter 7 where I examine stigma and sexuality.

## **FIELD STUDY**

I turn now to the data collected in the field interviews concerning beginning alcohol use and then tobacco use. In the field study, I explored the process of beginning drug use (see Appendix G for a detailed description of the definitions of first use). Following the definitions used in the NCADA survey, I defined first use of alcohol as the age at first drinking a full glass of alcohol, and tobacco as age at first smoking a full cigarette.

### **Alcohol**

All the 51 of the women interviewed had had at least one full glass of alcohol. Age at first having a full glass of alcohol ranged from 6 to 17 years. Like the women in the ACT Drug Indicators Project, the average age beginning alcohol use was in the early teens ( $x=13$  yrs,  $sd=2.5$ ). In the following sections, I examine regular use and then binge drinking.

#### ***Beginning regular use of alcohol***

Using the accepted definition of regular use (Bailey 1989), I coded all women who reported drinking at least one day a week as regular drinkers at that stage in their life. This definition does not identify problematic and unsafe drinking levels, as the amount drunk at each session is an important indicator of problematic drinking (National Health and Medical Research Council 1992; Pols and Hawks 1992). In the field study, 46 out

of the 51 women reported having drunk regularly and, for all 46 these occasions involved drinking more than one glass of alcohol. Although I recorded the age that women began regular drinking, not all continued to drink regularly from that age. The women had a variety of intervals of regular drinking. Several reported never drinking regularly although they had had occasional binge drinking sessions (binge drinking is discussed in the following sub-section). Table 5.3 in the previous section compares the 44 women who reported the age at which they began drinking regularly with comparable data from the Drug Indicators Project. Two women reported beginning drinking regularly as teenagers but neither could specify their age when they began to drink regularly so they are excluded from Table 5.3. Among the field study women, the age at beginning regular drinking ranged from 8 to 26 years with a mode of 15 years and a mean of 15.4 years ( $sd=2.7$ ), a year younger than the women in the Drug Indicators Project.

Those who drink regularly included some who drank in both a harmful and a non-harmful manner. May's story demonstrates harmful patterns of drinking. She began drinking regularly when she was less than 10 years old. Very few people began using alcohol regularly so young; only one woman in the field study and less than 1 per cent of the ACT Drug Indicators Project men and women. It seems that people who begin regular alcohol use at a young age generally are problematic drinkers and often have troubled childhoods. May's experiences illustrate some of the problems faced by these children.

May is the youngest in a family of four whose father deserted the family when she was a baby, but May grew up believing her father was dead. She lived with her mother, her mother's boyfriend and her sister and two brothers. Her childhood was marred by physical, emotional and sexual abuse. She tells the story of when she was 7 and she was first sexually abused by her mother's boyfriend:

He [mother's boyfriend] used to come and try, when he was drunk, you know, and touch me, and kiss me, and you know {sighs}. Not very pleasant. And it wasn't just a one-off occasion: it happened quite a few times y'know. My mother'd go out and drink, and y'know she'd go out and sometimes not come home for a week or 2 weeks, for days on end, you know. And we're stuck at home with this, just this guy, he'd come and go, and a box of food under the bed, and that was it, you know, or from donations, like y'know how they have Salvation Army here, Smith Family over there .... And my brothers were just breaking into houses next door, or just going out and partying or whatever, and god knows where my sister was, you know? And I was just there, and just [sighs].

May's had her first drink when she was about 7:

... a full glass, glasses, whatever, anything I could consume ... the next door neighbours, they had a party, and my mother had left us, and we just kept drinking and carrying on (May 25 yrs).

These were the same neighbourhood friends with whom May began smoking at about the same age. By eight, May was drinking regularly. But for her it was quite normal at the time:

... because at the time, because, like the environment I was in, it didn't seem anything. It was normal, and stuff. And because I was going through a lot of stress and emotional thing, like I didn't even know what feelings were, you know. And, like, it looked attractive and everyone was having a good time.

In this reconstructed memory, May displays a number of subject positions: as a woman, in recovery, and a child who enjoyed partying and drugs.

When she was eleven, May's mother died and May went to live with her aunt and uncle and their eight children for nearly a year before she was placed by Welfare in an institution for girls. I interviewed May when she was in treatment for alcohol and heroin dependency and she was making great strides in getting her life into order for herself and her five year old son.

And, yeah, I would like to, ... sort of change that pattern, not to pass it on to D [son]. I've had to let go of boyfriends, and people, and my house, and money and material things, know what I mean. It's like it wasn't easy, and it is still not... Yeah, I have high expectations of myself. More so because I was deprived when I was younger, and I never had all those things. And now that I have a child myself, you know, and I want to better his life, and not go through the past I had to go through.

May is doing much better than her two brothers; according to her relatives, one died of a heroin overdose and the other is in a psychiatric institution.

As in the field study, the findings from the Drug Indicators Project suggest that those people who began using alcohol regularly when they were under 10 years of age had severe problems with dependency. One man was serving a sentence for his third drink driving offence, and a number of other people reported they started using a range of other drugs, as well as alcohol, when they were under 10 years of age.

Conversely, there are some illegal drug users who use alcohol sparingly and safely. For example, two women in the field study had not become regular or binge drinkers. Both these women had used illegal drugs recreationally (such as cannabis and stimulants including ecstasy). Asked if they had ever drunk alcohol regularly, they indicated a lack of interest in alcohol.

### ***Binge drinking***

Binge drinking among the young in the general community has been a subject for increasing concern over the last decade ago or so (Bungey and Winter 1986; Binge Drinking Report 1987; Ellickson and Hays 1991; Commonwealth Department of Human Services and Health 1994). However, the phenomenon is more common among young males than females (Bell and Cumming 1989; Reynolds, Chambers et al. 1992; Victorian Department of Health and Community Services 1993). In the field study, a number of young women began binge drinking before they went on to drinking regularly. For example, Jay began having some binge drinking sessions at 14 years of age but did not start drinking regularly until she was 17 years old.

On the other hand, three women (Milly, Jo and Helga) did not become regular drinkers at any stage but reported infrequent binge drinking somewhere between a couple of times a month to two or three times a year. All of these women had been in treatment



for heroin dependency. Two were binge drinkers in their teenage years and the third woman began binge drinking when no heroin was available.

A number of regular heroin users who had been regular drinkers also had periods of binge drinking when they were 'hanging out' for heroin. It seems that for those who are dependent on heroin, binge drinking is one response to a shortage in the supply of heroin. While there have been a number of prevention projects educating youth on the dangers of binge drinking (Binge Drinking Report 1987; Kirk 1991), little attention has been paid to the harm associated with substituting large amount of alcohol for heroin.

### ***Tobacco***

Of the 51 women in the field study, three (6%) had never smoked a full cigarette and two of them expressed strong negative feelings towards cigarette smoking.

No. I hate it. I really hate it (Wendy, 20 yrs, ex-amphetamine dependency).

I hate it to bits....My grandfather smoked. He had cancer. I've never smoked (Martha, 33 yrs, ex-heroin user).

For these two women, it is seems that messages about the dangers of smoking plus their own experience had led to antagonistic feelings about smoking. The majority, however, had smoked at some time, and 84 per cent were smoking regularly at the time of the interview.

It is unusual to try cigarettes and then not proceed on to be a smoker. In the 1993 NCADA national population survey, only 7 per cent of 14 to 19 year olds had tried cigarettes and not gone on to smoke a full cigarette (Commonwealth Department of Human Services and Health 1993:45). In the field study, only one woman (Pearl) had tried cigarettes but had not gone on to smoke a full cigarette and she was a non-dependent user of illegal drugs.

I've never smoked a full cigarette, but I've had a few drags, probably in grade 8, but I've never smoked a full one in my life (Pearl, 21 yrs)

In Australia, it is generally assumed that most people who use illegal drugs also smoke tobacco but there is little research attempting to quantify this assumption. In a study of 20 Canberra recreational intravenous drug users, Dance (1989) found that all 20 were smokers. A US study into heroin dependency by Hser and co-workers (1987:46) found that less than 5 per cent had never used tobacco. Among the women in my field study, only 6 per cent had never taken up cigarette smoking compared to 32 per cent of the female population at large (Commonwealth Department of Human Services and Health 1994: 31) indicating that people who use illegal drugs are much more likely than the general population to smoke.

### ***The tobacco smokers***

There was great variety in the age that the women reported having smoked their first full cigarette (range 8-19 years) but the most common age was 11 years (12 women). The mean age for first smoking a full cigarette was 12.9 years (sd=2.6). By comparison, in a study of people in treatment in Perth nearly a decade earlier, Swensen (1983) found that the women, on average, reported first smoking at 14.9 years of age. The age that people have been beginning to smoke has been falling over the last few

decades particularly among women (Jones 1993: 38-39). In general, however, women in my field study reported beginning smoking at an earlier age than men and women in the NCADA household survey (Table 5.4).

**Table 5-4: Age when first smoked a full cigarette**

Age group	Field study %	NCADA 1991 %
Under 10 years old	8	6
10-11 years old	29	6
12-13 years old	19	18
14-15 years old	27	26
16-17 years old	11	19
18-19 years old	6	13
20 years and older	0	12
Total	100	100
Average age (Sample n)	13.0 (n=48)	14.2 (n=1951)

To make a comparison with the women in the general population, I compared the average age for starting among the 23 women aged 20 - 29 years with the women of the same age from the 1993 NCADA survey. The women in the field study began smoking on average a least a year younger than the women of the same age in the general population: at 13.4 years compared to 14.8 years for women in the general population. Males in this age group began smoking, on average, at 13.8 years, a year earlier than females (Jones 1993:Table 3.1). Similarly, among secondary school students in Victoria, males started smoking a little earlier than females: the average age for males was 11.9 years compared with 12.3 years for females (Victorian Department of Health and Community Services 1993:17).

A number of women reported trying cigarettes several years before having a full cigarette. Three women felt that they first smoked at an earlier age, 6 to 8 years, and for all of these women it was more than a few puffs but on questioning it seemed unlikely that they smoked a full cigarette, and that the occasion was a special one-off incident. None of these women smoked again until four or five years later. Nye, who reported smoking her first full cigarette at 13 years of age, added:

I tried my first cigarette when I was heaps younger, when I was six or eight years old. I sort of... A friend offered it to me, and thought I'd smoked, that's why she offered it to me, and that was the time, the first, I really started....Yeah, she didn't even realise, I didn't smoke (Nye, aged 16, experimental user of illegal drugs).

For these women, their first cigarettes were shared with either friends or siblings. For example, although she reported first smoking at 7, Janice added:

I shared it with a friend, so I think we smoked most of it, but then I didn't after that, so really probably started smoking tobacco at about 13 (when she began smoking daily).

Ella shared a packet of cigarettes with her brothers and describes her beginning use in stages:

I think 6 or 7 ..... A whole cigarette? I don't remember, actually, because we used to go in the cellar under the house and we used to get a packet of smokes just on the bill from my parents and we used to smoke it .... Oh, no, I think it was one off actually ..... I had my different stages, like when I was 11 I picked up (with) my girlfriends, just one packet, then we smoked it like a chimney, then we stopped, but when I really started smoking every day I was about 15, I think (Ella, 33 yrs).

Tricia's was a common story. She reported having 'a couple of drags' at about 10 years of age, and smoking a full cigarette at about age 12 when she brought her first packet.

Generally, the women showed similar patterns in beginning to smoke cigarettes: a stage when they tried a few puffs or 'drags' of a cigarette. Smoking a full cigarette occurred only some years later. But once having smoked a full cigarette, all of the 48 women went on to become regular smokers, some immediately but others up to 4 years after having the first cigarette. Three women reported beginning smoking cigarettes after first use of illegal drugs.

**Beginning regular smoking**

Age at beginning to smoke regularly ranged from 10 to 22 years but the most common age was 14 years (9 women). Table 5.5 shows the age distribution for beginning regular smoking. The mean age for beginning regular use was 14.9 years (sd=2.4). Of the three women who smoked their first full cigarette at 8 years of age, one was smoking daily by 10 and the other two by 12.

**Table 5-5: Age when began smoking regularly (n=48)**

Age group	Number	%
10-11 years	3	6
12-13 years	11	23
14-15 years	17	35
16-17 years	12	25
18-19 years	3	6
20 years or older	2	4

**COMPARING BEGINNING ALCOHOL AND TOBACCO USE**

This section describes the different social contexts related to beginning use of alcohol and tobacco. I conclude by comparing and contrasting beginning use of these legal drugs. I examine the setting, the physical environment where the women began smoking cigarettes and drinking alcohol, and social factors such as who they were with and how they obtained their first cigarette or alcoholic drink.

**Venues**

There are substantial differences between the venues where adolescents begin alcohol and tobacco use. For tobacco, school and school related places were among the most common environments for the women to smoke their first cigarette. Over a third (35%) reported first smoking in such places as school, school toilets, after school, after swimming training, on the oval, walking home from school. In contrast, only a few women (4%) began alcohol use in a school environment such as a school social event. Social occasions such as a party, or at a pub, nightclub, folk festival and other such

social places were the most common venues that the women reported having their first full glass of alcohol. Over a third of the women (35%) reported having their first drink at a social occasions or event (see Table 5.6). Only three women had their first cigarette in social settings such as a bar or party but two of these women (Gail and Regina) began smoking at the comparatively late age of 18 years, indicating that social events are an unusual place for young girls to begin smoking cigarettes.

In summary, school is the most common environment for beginning smoking whereas social settings are the most common for beginning alcohol use, and these differences can not be explained by age differences as alcohol use also started very soon after beginning smoking. Alcohol has played a significant part in social life and sociability in most industrial societies (Barrows and Room 1991). In their beginning drug use, adolescents are following the patterns of the dominant adult culture in using alcohol at social gatherings.

**Table 5-6: Venue for first use of tobacco and alcohol (n=51)**

	Alcohol %	Tobacco %
Social occasions (e.g. party, bar)	35	6
School and related places	4	35
Home or friend's home	29	33
Public venues (e.g. park, streets)	28	21
Can't remember/missing data	4	5
Total	100	100

Venues that were common for both alcohol and tobacco were the home (either ones own or a friend's) and public places (see Table 5.6). The family home was the most common place to begin drinking for those who had their first glass of alcohol when they were quite young. Of the nine women who had their first glass of alcohol when they were aged 10 or younger, eight began their drinking at home.

For a number of women, their first drink was also the first time they got drunk. Both Kim and May, who were later in treatment for drug dependency problems, had more than one glass when they had their first drink. For example Kim had: *'a whole bottle'* and May *'a full glass, glasses, whatever, anything I could consume'*. Kay also recalls getting drunk at eight years of age but for her it was a one off occasion.

It was my first holy communion. We stole a bottle of beer from the fridge and went out to drink it. But apart from that y'know, glasses of wine with family at Christmas and that sort of thing... It's a bit lousy y'know, you think, little kids in their first holy communion dresses running around with beers going... But family parties are a bit like that, y'know: everyone's sort of into it and you've got older cousins, and they're all having a glass of wine with, y'know, sophisticates (Kay, 19 yrs).

Jewell remembers first getting drunk at the age of 13:

I was with two girls from my school and we were like dancing, and then her Mum comes out, 'cos her mum's Egyptian, and her mum had put a little Egyptian alcohol that was ten years old, and very potent, and we got so drunk, 'cos we drank the whole thing. We just had no idea, we drank the whole thing, and I remember falling, like seeing my face go whooo, gone, and then I remember waking up in a bed that I didn't get into, in clean clothes. Cos her mum had found us all roaring drunk and dunno! Yes, it wasn't very good. It was good experience though; don't get that drunk anymore. Not very nice, not a good sensation, to be totally out of it (Jewell, 17 yrs).

In relation to beginning drug use in a public place, parks and outdoor recreation areas were common places where young people gathered and tried their first drink (28%) whereas for tobacco, the street and bus interchanges were also places for having that first cigarette.

**Companions**

Not surprisingly, given the predominance of the school environment and the young average age for beginning smoking, companions in these first smoking ventures were generally girlfriends (42%). However, the next most common group were simply friends/acquaintances of both sexes. None of the women reported being introduced to tobacco smoking by a boyfriend.

In contrast, alcohol was tried most commonly with a number of friends, as would be expected in social occasions, rather than just with a girlfriend as frequently occurred when trying out cigarettes (Table 5.7).

**Table 5-7: Source of introduction to cigarettes and alcohol**

	Alcohol %	Tobacco %
Girlfriend(s)	14	42
Friends /acquaintances (mixed sexes)	55	27
Family	14	17
Self	12	13
Boyfriend(s)	4	0
Can't remember/missing data	2	6
Total	100	105 <sup>a</sup>
Total responses	51	50
(Sample n)	51	48

a Multiple responses were coded when it was not possibly to determine the most important source. Thus, percentages total more than 100. Percentages were calculated on the number of women in the sample who had used the drug (n=48 for tobacco).

In the wider community, peers and family members are influential in beginning cigarette use (U.S. Department of Health and Human Services, 1994) and beginning to drink alcohol regularly (Victorian Department of Health and Community Services 1993). Amongst illegal drug users, family members were also an important source for beginning use of tobacco and alcohol although the types of family members varied with the type of drug. Relatives who were the source of cigarettes were generally older sisters, brothers and cousins whereas parents as well as siblings and cousins also played a part in introducing the women to alcohol. The women who began drinking with their parents first tried alcohol on special occasions, such as Christmas or family celebrations or at a family meal.

For those who first drank with their siblings, however, it was an illicit secret activity hidden away from parents and other authority figures.

To varying degrees, there was an element of self initiation for most of the women in first trying alcohol and cigarettes. Over 10 per cent sought out and obtained their first cigarette or drink by themselves. For example, self motivation was the primary reason for their first drink for 12 per cent of the women (see Table 5.7). These women frequently obtained their alcohol in the family home.

Yes, it was a full glass. I was on my own. You know, both my parents had a dinner party and I had to clean up the next morning ... It was red wine (Fern, 30 yrs).

It was at one of my own birthday parties, there was a couple of older girls there and dad had a little bar thing, (we) found it, thought, oh, we'll have some of that (Cissy, 29 yrs).

In relation to tobacco, a similar proportion of women (13%) sought out their first cigarette for themselves. Those who started smoking at a young age obtained their first cigarettes by stealing from relatives: Kay, at 8, from her father; Jay, at about 11, from her mother; and Kit remembers stealing, when she was 12, from her sister.

Yeah, in the middle of the oval by myself, with my yellow bike: I remember that! I do remember that ciggie. I stole one off my sister, and went down the oval and smoked it by myself. I was fascinated by it. I remember being scared to death too, right smack bang in the middle of the field, and looking around. It wasn't cool (Kit, aged 25).

Gay, however, obtained her first cigarette (at 15) through a school friend but still of her own volition.

I ... went to boarding school in Sydney, and there was this one girl in the form that was so addicted to smoking, like she used to smoke all the time. And I'd become friends with her, like over the last 6 months. And she just, and I used to go with her, like for company, when she used to go and have cigarettes. And then once I just wanted to try it: like (pause) I'd never even thought about it before, I just, then I wanted to try it, and I did (Gay, aged 19).

The remaining women who took up smoking of their own volition began smoking cigarettes at older ages (Tara at 19 yrs, Deidre at 17 yrs) after they had been using illegal drugs for some years. Tara used tobacco as a antidote to stress.

I just decided ... I'd split up from a relationship and I finally discovered that nicotine was a really powerful drug that calmed me down no end (Tara had been using cannabis for 4 years at this stage).

Boyfriends played a minor role as companions in beginning use of alcohol but none at all for cigarettes. Thus, it is clear that males play a very minor role in introducing females to legal drugs, unlike the pattern that has been suggested to prevail for the introduction of illegal drugs.

## CONCLUSIONS

Although male companions played no significant role in beginning legal drug use, there were other interesting gender aspects. Illegal drug users show similar gender patterns in their first use of the legal drugs as teenagers in the wider community, and it can be argued that the social construction of gender is implicated in the patterns of beginning legal drug use. The case of alcohol demonstrates the point. Males begin drinking alcohol at a younger age than females. The reasons for this gender difference in beginning drug use are not readily apparent and reflect subtle gender-specific norms for males and females. Gender theorising provides one partial explanation for the age differences. For females, the imperative to be a good woman, a 'nice' girl, is a constraint against a young girl using alcohol. For males, there are no such constraints. On the contrary, the ability to 'hold your alcohol' has been a symbol of masculinity. As well, there are other discourses about alcohol, such as the pleasure discourse which associates alcohol use with fun, partying and adulthood and which encourages young people, both male and female, to try alcohol. But the different gender norms could act as a constraint on females and account, in part, for their beginning use alcohol later than males.

Beginning regular use of alcohol, however, showed different gender patterns. Whereas, the older women in the ACT Drug Indicators Project had continued the gender pattern of beginning use at an later age than the males, the younger women began using alcohol regularly at a earlier age than their male counterparts. This, I have argued, may reflect the contemporary attitude towards intoxication among illegal drug users which celebrates the use of 'intoxicating drugs' (Dance and Mugford 1992) and does not place the constraints on women's drunkenness that occurs in the wider society.

Similarly, such an attitude to intoxication may partly explain the finding that illicit drug users begin using legal drugs younger than the general population. Over the last 20 years, education regarding the harm of cigarette smoking has resulted in a large decrease in the prevalence of smoking among men and a small decrease in women. However, the fall in the levels of smoking have occurred differently in different parts of the population. A number of sub-populations, such as the unemployed (Stanton, Gillespie et al. 1995), working class and Aboriginal people (Brady 1991), have been noted as still having high levels of smoking. People who use illegal drugs are another group who display alarmingly high rates of tobacco smoking. Binge drinking is also a health problem among this population.

Harm minimisation policies and education have been useful in suggesting safer ways of using illegal drugs. However, little attention has so far been given to educating potential, present and past illegal drug users about the dangers of legal drugs and reducing the incidence of harm from legal drugs among this sub-population. Reaching this group is going to require new strategies which address the different social characteristics, including age and gender differences, among illicit drug users (Clayton 1991; National Drug Strategy Adolescent Smoking 1994).

This chapter has addressed some facets of these age and gender variables and I have suggested that there are meaningful differences in relation to how some groups of women perceive legal drugs such as alcohol. Similar arguments have been made

regarding tobacco. A number of researchers have argued that smoking and the initiation of smoking is invested with social meaning and identity (Clayton 1991; Banwell and Young 1993; National Drug Strategy Adolescent Smoking 1994). Banwell and Young (1993) argue that young women who took up smoking tended to reject, for themselves, the popular stereotypical representation of 'good woman'. For them, smoking is one of the props of the stereotypical representation of the 'bad woman' and is a symbol of adulthood with which they identify. A qualitative study on adolescent smoking found that while for early secondary school children, smoking was a symbol of the 'rebel', by late secondary school girls smoking was a symbol of the sophisticated sexual 'vamp' (National Drug Strategy Adolescent Smoking 1995). Thus, conventional anti-smoking health messages have little relevance for young women who have chosen such a social identity for themselves.

In this chapter, I have shown that boys tend to take up the use of legal drugs younger than girls, although the age gap has been decreasing over the last two to three decades to the point where now difference is quite small. In the past, the cultural mores which represented women who drank and smoked as 'not nice women' acted as controls on women taking up alcohol (Sargent 1979) and cigarettes. These controls appear to be attenuating.

I have argued that young women who become illegal drug users tend to have rejected the cultural values of the wider society which sexually denigrate women who are drunk. They accept for themselves notions of adulthood which contain fun and excitement and reject notions of containment and control that inform the good woman image.

Elements of these mores persist today and contribute differently to boys and girls beginning to use alcohol and cigarettes. However, values are changing and are not equally relevant to all sectors of the population. Health promotion activities in relation to smoking and binge drinking must take these changing and variable values into account.



## CHAPTER 6: BEGINNING TO USE ILLEGAL DRUGS

This chapter examines gender aspects of initiation into illegal drugs similar to those discussed in the previous chapter on legal drugs. One purpose of this chapter is to explore the process by which Australian women begin using illegal drugs and test the claim that women are introduced to illegal drugs by men. In Australia, little is known about such a basic question as the ages at which people begin to use illegal drugs. The 1993 NCADA Household Survey was the first national survey to ask respondents about their age when they began to use a range of illegal drugs. However, because, in a population survey, comparatively few people report use of the illegal drugs other than cannabis (Makkai and McAllister 1994; Larson and Bammer 1996) it is difficult to examine gender and age differences in relation to the use of any other illegal drugs. The ACT Drug Indicators Project provides a large enough sample of illegal drug users to study a range of variables including age and gender differences. In this chapter, I use the ACT Drug Indicators Project data to compare the patterns among males and females for initial use and regular use of cannabis, amphetamines, hallucinogens, heroin and cocaine.

In addition, I compare the women in the Drug Indicators Project with the women in the field study and consider the social context of beginning use described by the women in the field study. In the field study, I investigated the process by which the women moved into illegal drug use and I explored the suggestion from overseas studies that women are introduced to illegal drugs by men (Hser, Anglin et al. 1987). There is some evidence from a study on cocaine use in Australia that this may also be true for Australian women. Pilkinton (1989), in an analysis of recreational cocaine users in Sydney, Melbourne and Canberra, did not study beginning use but she did analyse methods of obtaining cocaine. She found that over half of women (53%) acquired cocaine as a gift, whereas nearly all the men purchased their supplies. It seems that some of the social customs that apply to alcohol (such as the common practice of buying a woman a drink) is replicated in cocaine use.

### CANNABIS<sup>18</sup>

#### *Age and gender differences in initiation*

At first glance, there appears to be little difference between males and females in their age at beginning to use cannabis; on average males began cannabis use at 15.9 years (sd=3.9) and the females at 15.7 years (sd=4). This suggests a different gender pattern from the legal drugs where males began use at a younger age than females. Table 6.1 shows the proportion of males and females in each age group when they first tried cannabis. These data suggest similarities between men and women in beginning cannabis use.

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<sup>18</sup> Cannabis refers to both leaf products and hashish although most people began using cannabis as leaf.

Table 6-1: Percentage in each age group when first used cannabis

Age Group at first use	ACT Drug Indicators Project		Field study
	% Males	% Females	% Females
	(n=410)	(n=235)	(n=51)
	(1988-89)		(1992)
Under 10 years	1	<1	2
10-11 years	4	5	4
12-13 years	17	23	24
14-15 years	27	31	39
16-17 years	30	21	20
18-19 years	11	7	9
20-21 years	5	6	2
22 years and older	5	6	0
Total	100	100	100
Average age	15.9	15.7	14.5
Median age	15.5	15.0	-

However, as for alcohol, age at first use varies significantly for the different age cohorts. Those over 40 years of age had first tried cannabis on average at age 25. After this, age at first use fell by about 2 years per decade, with those in their thirties reporting first use on average at 17.8 years and those in their twenties at 15.1 years. Those under 20 years of age report first trying cannabis on average at 13.5 years of age. Analysis of age at first use showed that both current age and sex are significantly associated with age at first trying cannabis. Regression analysis controlling for age shows that, on average, males began cannabis use when they were about 6 months (0.599 years)<sup>19</sup> younger than females.

Jones (1993:51) found that there was a substantial increase in marijuana use in the 1980s and since that period the gender gap has narrowed. Donnelly and Hall (1994) argue the cannabis use increased substantially throughout the 1970s and 1980s, levelled off in the late 1980s, and has probably shown a small increase in the early 1990s. The ACT Drug Indicators Project data support Jones' hypothesis that the difference between males and female in the patterns of cannabis use has been steadily narrowing and, for those under 30 years, there is no significant difference between males and females in the age at beginning use. In a regression analysis for those under 30 years of age, sex is not significantly associated with age at first use but age of the respondent remains a significant indicator.

The DIP sample of illegal drug users began cannabis use at an earlier age than those in the general population. Jones, in an examination of the 1993 NCADA survey, found that the median age of initiation for cannabis in the Australian population was 18.3 years whereas in the ACT Drug Indicators Project sample the median age was 15 years. However, the DIP sample, which is a treatment population, resembled the age of initiation in a treatment sample in California studied by Hser and co-workers (1986), who, in a sample of people in methadone maintenance, found that white (Anglo) males began cannabis use at 15 years of age and white females at 16 years of age (not a significant difference).

<sup>19</sup> The equation is Age at first use of cannabis = 7.38 + .34(age) - .599(sex where 1=male, 0=female).

The field study women showed similar patterns of beginning use of cannabis to the ACT Drug Indicators Project women (see Table 6.1). All of the women in the field study had tried cannabis. The women reported first trying cannabis at ages ranging from 8 to 20 years. The most common (modal) age for beginning cannabis use was 14 years, with the mean being 14.5 years ( $sd = 2.2$ ) which was slightly younger than the average age for the ACT Drug Indicators Project women.

Except for Pearl, all the women were 11 years or older when they first tried cannabis. Pearl first tried cannabis at 8 years of age when she was living in India in a 'hippie' environment:

I grew up in India, right, with my mum; she's a really, really full-on hippie ... all the kids used to run off together, and you'd say oh, see you at sunset or something. Then we'd go... there was about 15, 20 of us. And um, we useta just all get into everything; like we were right into sex n'right into smoking. One of my friends had a trip at 12. And so we useta smoke pipes, and dope... Oh, from about 8 to 11 I lived in India, yeah. So I prob'ly would've had my first smoke at about 8. Not, not seriously, you know, but just the same, just trying it out as a kid.

So for Pearl, her environment provided an opportunity to try a few puffs of cannabis as other children in different environments would first try out cigarettes. Pearl did not get to try a few 'drags' of a cigarette until she was living in Australia in her early teenage years. But that was as far as she went with cigarettes. However, she became a regular user of cannabis between 17 and 19 years of age and then she gave it up for a time. She now only smokes 'joints' very occasionally in social situations (e.g. only one period in the last 2 years).

### ***Regular Use of Cannabis***

There was no significant difference between the sexes regarding their age at beginning to use cannabis regularly; females began at 16.1 years of age ( $sd = 3.99$ ) and males at 16.6 years ( $sd = 3.78$ ) (see Table 6.2). Again, age is a significant factor. Regression analysis showed a significant association between the age of the people in the ACT Drug Indicators Project sample with age at beginning to use cannabis regularly. On average, the age of moving to regular use of cannabis occurred 0.34 years earlier, for each year that the age of the individual in the sample decreased. That is, as with first use, the younger the person, the earlier, on average, they had begun using cannabis regularly. There was no significant interaction between age and sex for beginning regular use.

For the women in the field study, I defined regular use as using cannabis at least once a week for at least one time period. Of the 51 women in the field study, four did not go on to become regular users of cannabis. One woman, Cissy was an intermittent user of cannabis until she stopped at 21 when she began using heroin. In her opinion, she had found a better alternative.

**Table 6-2: Percentage in each age group at first regular use of cannabis**

Age Group	ACT Drug Indicators Project		Field study
	% Males (n=345) (1988-89)	% Females (n=204)	% Females (n=40) (1992)
Under 10 years	1	1	0
10-11 years	3	2	2.5
12-13 years	11	18	22.5
14-15 years	24	31	27.5
16-17 years	31	27	25.0
18-19 years	17	8	7.5
20-21 years	5	6	7.5
22 years and older	8	7	7.5
Total	100	100	100
Average age	16.6	16.1	16.1
Median age	16.0	15.0	-

Three women found that the drug produced unpleasant hallucinogenic effects; Lisa began using cannabis at 14 but stopped when she was 16, Rosemary used between the ages of 16 and 18, and Kayleen first tried out marijuana at 18 but found she was, as she described it, ‘psychologically allergic’ to both cannabis and hallucinogens.

Yeah, so I used to have to pretend to smoke (cannabis) because I could not tolerate it (Kayleen, 40 years).

For Kayleen, it was important that her illegal drug using peer group believed that she was also smoking cannabis, indicating the significance of the peer group in beginning drug use.

There were seven women who began using cannabis regularly for some periods as teenagers but they did not specify an exact age. For the remaining 40 women who reported on their precise age of regular use (see Table 6.2), the average age for becoming regular users was 16.1 years (sd= 3.6) which was about 18 months after first trying cannabis. The patterns were quite similar for the ACT Drug Indicators Project and field study with both groups of women beginning regular use at the same average age.

**AMPHETAMINES AND HALLUCINOGENS**

**First use of amphetamines**

There were different gender patterns for amphetamines. As was suggested by an interim report from the ACT Drug Indicators Project (Kieboom, Stevens et al. 1990), it appears that females began amphetamine use when they were a year younger than males. There was a significant difference between males and females in the average age when they began to use amphetamines (t=2.7, p=0.005) with the women beginning to use amphetamines at 18.3 years (sd=4.3) and the males a year later, at 19.3 years (sd=4.4). Table 6.3 shows the proportion of males and females in each age group when they first tried amphetamines. The median age for first use also indicates that females began using amphetamines at a younger age than the males.

When controlling for age, however, the difference between the sexes was not

statistically significant. Again, regression analysis shows there is a significant relationship between age of the respondent and age at first use of the drug, with amphetamines use beginning 0.38 years earlier among the progressively younger people. For those over thirty, the average age for first use of amphetamines was 22.4 years whereas for teenagers it was 15.7 years. There was no interaction between sex and age.

**Table 6-3: Proportion in each age group at first use of amphetamines**

Age Group at first use	ACT Drug Indicators Project		Field study
	% Males (n=302) (1988-89)	% Females (n=163)	% Females (n=47) (1992)
10-11 years	<1	1	0
12-13 years	3	5	2
14-15 years	12	18	17
16-17 years	22	31	41
18-19 years	17	8	7.5
20-21 years	19	11	15
22-23 years	5	4	6
24-25 years	5	4	2
26-27 years	3	4	0
28-29 years	3	2	2
30 years and older	4	3	0
Total	100	100	100
Average age	19.3	18.3	17.8
Median age	18.0	17.0	-

Forty seven women in the field study had tried amphetamines, which most of the women referred to as 'speed'<sup>20</sup>. Age for first use ranged between 12 and 28 years with a mean of 17.8 years (sd=3.04) and a mode of 17 years (11 women). Table 6.3. shows the proportion of males and females at each age group when they first tried amphetamines.

Four women from the field study had not used amphetamines. Three of these women were teenagers who may go on to use amphetamines later; all three had used cannabis and experimented with hallucinogens, and were still at the stage of 'playing' and experimenting with illegal drugs. The fourth woman, Cissy (29 yrs) is unlikely ever to use amphetamines. She had been dependent on heroin but became abstinent five years ago when she entered and successfully, after many attempts, completed a drug treatment program at a therapeutic community. Previous research has shown that the longer the period of treatment and abstinence, the greater the likelihood of not returning to illegal drug use (Mattick and Hall 1993).

Bevan and co-workers (1996) found that among injecting drug users in Perth, the average age for first use of amphetamines was 19.3 years which is somewhat older than those in the ACT. However, Hser found that Anglos in treatment in California, both

<sup>20</sup> Ten of the women had used ecstasy as well as 'speed'. Data on the designer drugs are not analysed separately. In the ACT Drug Indicators Project, the few people reporting ecstasy use were included with those using amphetamines (see Chapter 4).

males and females, began oral amphetamine use at 17 years of age which is earlier than those in the ACT. Both the Perth and California studies, however, collected data on initiation separately for oral and injecting. The age for first injecting amphetamines was older than first oral use in both studies. The ACT data does not differentiate between oral and injecting in initiation of amphetamines so this complicates the comparisons between my study and the data from Perth and California.

First use of hallucinogens

At first glance, it appears that females reported trying hallucinogens a year earlier than males ( $t=2.5$ ,  $p=0.01$ ); women at nearly 17 years and males at nearly 18 years of age (see Table 6.4). However, as for amphetamines, regression analysis controlling for age shows that the differences between the sexes is not significant and the only significant difference can be explained by the ages of the respondents. Age at beginning to use hallucinogens fell by 0.23 years as the age of the respondents in the sample decreased. There was no significant interaction between age and sex.

Table 6.4: Percentage in each age group at use of hallucinogens

Age Group at first use	ACT Drug Indicators		Field study
	% Males (n=234)	% Females (n=103)	% Females (n=46)
	(1988-89)		(1992)
10-11 years	<1	1	2
12-13 years	2	9	0
14-15 years	23	24	33
16-17 years	29	28	22
18-19 years	29	27	26
20 years and older	18	11	17
Total	101 <sup>a</sup>	100	100
Average age	17.7	16.8	17.4
Median age	17.0	17.0	-

a Due to rounding the percentages do not always total 100.

The average age of initiation into hallucinogens in the ACT is similar to the California methadone maintenance study by Hser and co-workers who found that white women first used on average at 17 and males at 18 years (Hser, Anglin et al. 1987:47).

Forty six women in the field study had used hallucinogens<sup>21</sup>. There was a wide range in the age of first use of hallucinogens, from 11 to 29 years, with the average age for beginning use 17.4 years (sd = 3.2) and the mode 15 years (12 women). Of the five women who had not used hallucinogens, four are unlikely to do so. Three (Tricia, Helga and Cissy) had been through a treatment program<sup>22</sup> and now given up illegal drugs. The fourth, Melinda had started using illegal drugs when she was 17 and had used a number of drugs (cannabis, ‘speed’, cocaine) but said she was ‘too scared’ to use hallucinogens. The fifth woman (Lawrie) who had not used hallucinogens was still in

21 Hallucinogens mentioned were mushrooms, LSD, trips, mescaline and ‘acid’. “Trips” and mushrooms were the two most common hallucinogens used. Pure LSD is rare nowadays in the ACT and elsewhere in Australia and these drugs are more accurately referred to ‘trips’. Tablets sold as LSD may contain a variety of hallucinogens and may, in addition, contain amphetamines (Stevens 1991:7).

22 None of these women had grown up or used in the ACT.

her teens. She had not been offered hallucinogens but she may try the drug later if she has the opportunity. Of the women who used hallucinogens, most did so intermittently and had used psychedelic mushrooms, which are readily available, before using other hallucinogens. Nina's story in response to the query about hallucinogens demonstrates some common experiences.

I think the first was mushrooms, and I had them when I was in college, 'cos that was pretty common sort of thing. So I guess I would've been, oh, I think I was 16. And that was just a big group of {us}, went to this girl's house, there was a party there, and there were some mushrooms, so I had some... I have sort of had them intermittently, occasionally, like I probably had them about 20 times or so, in the last few years...The first trip I had was when I was 19. That was at a party in Sydney, at our house, and a guy brought along a pile of trips so I had one. I've only had about 4 trips (Nina, 23 yrs).

The intermittent use of hallucinogens was quite different to the much more regular patterns of amphetamines.

**Regular use of amphetamines**

Only half the men in the ACT Drug Indicators Project sample went on to use amphetamines regularly, but nearly three quarters of the women did so. The significant sex difference in age at beginning regular use ( $t=3.42$ ,  $p=0.001$ ) (see Table 6.5) disappears when controlled for age. However, there is a significant interaction between age and sex<sup>23</sup>.

**Table 6-5: Age at shifting to regular amphetamine use**

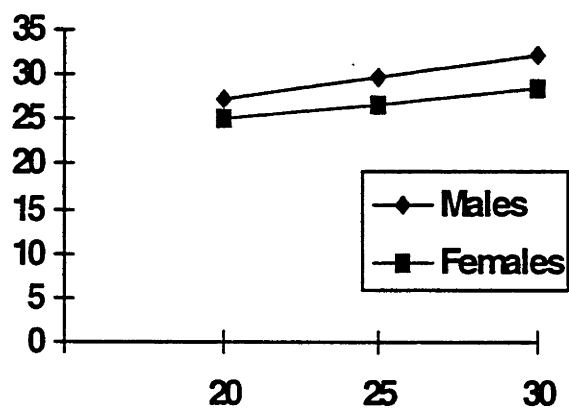
Age Group	ACT Drug Indicators Project		Field study % Females (n=29) (1992)
	% Males (n=154) (1988-89)	% Females (n=119)	
10-11 years	<1	0	0
12-13 years	3	5	0
14-15 years	14	18	10
16-17 years	23	32	32
18-19 years	16	18	21
20-21 years	16	10	14
22-23 years	7	8	10
24-25 years	6	4	7
26-27 years	2	3	1
28-29 years	5	1	0
30 years and older	6	2	7
Total	99	101	101
Average age	19.8	18.0	19.2
Median age	19.0	17.0	-

Due to rounding the percentages do not always total 100

In all age cohorts, females report beginning regular amphetamine at a younger age than males but the slope for the males is steeper indicating a greater increment for age for the males (see Figure 6.1).

<sup>23</sup> The equation is: Age at beginning regular amphetamine use = 18.77 + .32(age) - .97(sex) + .16(age\*sex).

**Figure 6.1: Comparison of relationship between males and females at age of beginning regular use of amphetamines (ACT Drug Indicators Project)**



This is further demonstrated in the average age at beginning regular use in the different age cohorts. In those under 20 years, on average, females began regular use nearly a year earlier than the males; at 15.6 years versus 16.4 years for boys. But in those over 30 years of age, the females began regular use on average nearly 4 years earlier than the males; 20.1 years versus 24 years for the males<sup>24</sup>.

The patterns of beginning amphetamine use provide some interesting gender differences. On examination of first use, it appeared the women in the ACT Drug Indicators Project sample began amphetamine use at an earlier age than the males, although closer analysis showed that these differences are not statistically significant. However, for those who went on to become regular amphetamine users, the gender differences are more accentuated and are statistically significant. Further evidence of this gender difference in amphetamine use is indicated in the greater proportion of women who had gone to become regular users. As noted previously, three quarters of the women who had tried amphetamines went on to become regular users compared to only half of the men. For the women who were regular users, the average age for first use was 17.5 years (sd = 3.6) and regular use began, on average, just six months later at 18 years of age.

In the field study, 28 women (60% of those who had tried amphetamines) went on to use amphetamines regularly (at least once a week) for at least one time period. Within that definition, regular use varied greatly. Some women were using daily for at least a couple of weeks and others had ‘speed binges’ (using 2-3 times a day) at least once a week for some period(s). For the 28 women who used regularly, the average age at beginning regular use was 19.2 years (sd=3.7) which is not quite two years later than their average age (17.8 yrs) for starting to use amphetamines. However, the average age hides some of the differences among the women. Twelve women used regularly from the beginning but other used intermittently before becoming regular users. Fern and Lawrie were two who used regularly from the beginning.

<sup>24</sup>There were only 14 women reporting regular use of amphetamines in the over 30 years age cohort and so the findings could be subject to sampling variation.



I took my first speed habit when I was about 17...Yes. I used it chronically for about a year, one every day at least, maybe three times a day, I was dealing it, and then I just stopped using it (Fern, 30 yrs).

Just before my 18th birthday... I used speed for about five to six months and in that time I was using it four to five times a week.... Most-, during the week I'd only use it once but on the weekend maybe once or twice or three (Lawrie 18, yrs).

### Regular use of hallucinogens

Unlike amphetamines, only a minority of people in either study reported using hallucinogens regularly. About a third of the ACT Drug Indicators Project men and women who had ever tried hallucinogens reported using them regularly. The women began regular use, on average at 16.4 years of age (sd = 2.4) and the men on average at least a year later at 17.7 (sd = 3.4) (see Table 6.6).

It should be noted that for women the average age for first use is slightly older (16.8 yrs) than the average age *for beginning regular* use (16.4 yrs). This anomaly is due to the group of regular users being a sub-group of all those who had tried hallucinogens. The mean age for first use for the sub-group of 38 women who reported regular use was 15.8 years (sd = 2.1).

There was a significant difference between the sexes regarding age at beginning to use regularly ( $t=2.07$ ,  $p=0.04$ ). However, a regression analysis controlling for age shows that the difference between males and females can be explained by age. As with regular use of cannabis, there was no significant interaction between sex and age.

**Table 6-6: Age at shifting to regular hallucinogen use**

Age Group	ACT Drug Indicators Project		Field study % Females (n=7) (1992)
	% Males (n=85) (1988-89)	% Females (n=38)	
10-11 years	1	0	0
12-13 years	2	13	0
14-15 years	26	18	29
16-17 years	26	37	14
18-19 years	27	24	14
20 years and older	18	8	43
Total	100	100	100
Average age	17.7	16.4	*
Median age	17.0	17.0	-

\* Not calculated because the small number of cases reduced the meaningfulness of the statistical calculations.

Of the 46 women in the field study who had used hallucinogens, only seven (15%) reported ever using them regularly. As with the other drugs, I defined regular use as at least once a week for some period of time. Two women's use of hallucinogens did not fit that definition of regular use but nevertheless on response to my question on regular use, they replied in the affirmative according to their own definitions - they considered they had used hallucinogens regularly.

Oh, I did, yeah, for a while: for about 2 years, had it prob'ly, I was having like about 3 a month, for a while, like, for about 2, 3 months there. But I was having them like, prob'ly would've been {pause}. I've lost count how many acid trips I've had. And mushrooms I've only used twice (Pearl, 21 yrs)

Mm, when I bought those I did: like, in a week I took about 2 or 3 then. And then I had more after that week, and then I had it in Nimbin. I had about 5 trips this year so far (Zara, 17 years - interviewed in October).

Hallucinogens, it seems, are drugs that generally are not used as regularly as occurs with cannabis and amphetamines. In part, this may be because it is difficult to work or study while hallucinating. It can not readily be combined with a life of routine and daily employment or domestic responsibility. Taking hallucinogens regularly, thus, is an activity in itself and is generally used as part of recreation, unlike the other drugs which can be incorporated into both work and play.

Regular use of hallucinogens is more common among people whose overall drug use is heavy. A larger proportion of women in drug treatment (one third) reported regular use of hallucinogens than those in the field study (15%). However, some people in the ACT Drug Indicators Project study may not have fit my criteria of regular use as defined for the field study creating an underestimate in the field study compared to the ACT Drug Indicators Project study. To allow a better comparison, I included the two women in the field study who did not fit the criteria for regular use but who defined themselves as regular users (thus using the same self definition as used in the ACT Drug Indicators Project study). Using these calculations, 20 per cent (9 women) in the field study reported regular use of hallucinogens compared to a third in the ACT Drug Indicators Project study. And of the nine in the field study who reported using hallucinogens regularly, four had been in treatment.

Jo was one of the women who had been in treatment and who had used hallucinogens regularly (daily drinking orange juice laced with LSD) but at that stage in her life, she was immersed in the drug culture and it was the dominant activity in her life; she had no job, study or family responsibilities. Jo had the time to spend in regular use of hallucinogens as she had no other responsibilities. Carmel was one of the women who had used regularly at some stage but she had never attended a drug treatment agency. She explains how she came to use regularly.

I've had a few binges on them, but I only did because I was trying to buy in bulk n'stuff like that, and so I had a lot more access. I've never bought bulk speed, 've only bought bulk acid....but I really like shooting it up, so it's a lot easier for me on my own, .... if I wanna take drugs by myself and not with anyone else, acid's a lot easier for me to deal with (Carmel, 26 yrs).

Two things contributed to the opportunity for Carmel to use hallucinogens (acid) regularly: a ready source of the drug by bulk buying and time on her own. Carmel was on a sickness benefit when I interviewed her. She did not have an occupation, having worked irregularly at odd jobs and she had no family responsibility although she was very caring and motherly to her drug using friends. As with Jo, it can be seen that regular use of hallucinogens does not fit in with a lifestyle which involves work, study or family responsibilities. In other words, regular use of hallucinogens is much more difficult to incorporate into a varied lifestyle than regular use of other drugs.

## HEROIN

In Australia, more is known about the patterns of beginning heroin use than about other illegal drugs except for cannabis. One of the earliest studies examined the characteristics and attitudes of the people in the first methadone maintenance program in Australia (Reynolds 1973). The majority of those in the program were male (72%) and the females were younger than the males. Reynolds noted females started using heroin at an earlier age than males (p.16), a surprising finding given that in the 1970s males began to use legal drugs such as alcohol and tobacco before females. In a two year follow-up study of Sydney methadone clients Reynolds and Magro (1975; Reynolds and Magro 1976) did not conduct an analysis by gender. They reported that the 'most frequent age for starting using opiates was between 16 and 17 years and in the majority of cases at least three years had elapsed between starting on opiates and being in the methadone programme'. Prior to beginning heroin use, the great majority of clients 'had smoked marijuana, taken amphetamines and LSD usually either whilst still at school or soon after leaving school' (Reynolds and Magro 1975:49).

Nearly two decades later, Caplehorn and Saunders (1993), reporting on detoxification and methadone clients in Sydney treatment programs, found that the mean age for beginning heroin use in these clients was 18.3 years for detoxification clients and 19 years for methadone clients (not a significant difference.) . At the time of their study, the methadone clients were slightly older (mean age 28.2 vs 27.6 for detox clients, but again not significant). Similarly, a study on HIV and injecting drug use reported that respondents in Perth first used heroin at 18.7 years (Bevan, Loxley et al. 1996:83)

In the ACT Drug Indicators Project data, there was no significant difference between males and females in regard to their age at beginning to use heroin ( $t=1.49$ ,  $p=0.14$ ). On average, females began using heroin at 18.6 years and males at 19 years (see Table 6.7). Age at beginning to use heroin ranged from 12 to 39 years. Similarly, Hser and co-workers (1987) found that among Anglos in California, there was no significant difference in initiation age for heroin use, with both sexes first using heroin at 19 years of age. Among the California Chicanos, however, males began using heroin at a significantly younger age - on average, two years before Chicanos females. The gender differences among Chicanos reflect the gender patterns noted by Hser and co-workers in earlier US heroin studies. In the 1980s, however, both the Anglo Californian and the predominantly Anglo Australians in the ACT showed similar patterns for males and females while the Chicanos maintained the traditional gender differences. A 1990s study of women in New York City found the women first trying heroin at 17 years of age (Faupel and Hanke 1993) - two years earlier than the 1980s studies in Australia and California.

In my field study sample, thirty eight women had used heroin and their ages when first using heroin ranged from 13 to 33 years. However, most of the women did not begin to use heroin until they were in their late teens or older. The average age for first use was 19.4 years ( $sd= 4.5$ ) with a mode of 17 years (8 women) - see Table 6.7.

**Table 6-7: Age when first used heroin**

Age Group at first use	ACT Drug Indicators Project		Field study % Females (n=38) (1992)
	% Males (n=225) (1988-89)	% Females (n=111)	
12-13 years	4	4	5
14-15 years	10	20	10
16-17 years	32	21	29
18-19 years	22	21	18
20-21 years	12	13	16
22-23 years	7	8	3
24-25 years	4	8	8
26-27 years	4	3	3
28-29 years	2	1	3
30 years and older	4	1	5
Total	101*	100	100
Average age	19.0	18.6	19.4

\* Due to rounding the percentages do not always total 100

Of the 13 women who had not used heroin, 7 were teenagers, some of whom may go on to use heroin later. Some of these teenagers were experimenting with drugs as often occurs among youths (McAllister, Moore et al. 1991:11) but they may be part of the population that does not go on to use drugs such as heroin (Kandel and Yamaguchi 1985). Considering the circumstances of the women aged 20 years and older, they appear unlikely to go on to use heroin. One of the women (Wendy, 20 years) had been through a treatment program for speed dependency after temporarily losing custody of her two pre-school children. At interview she was abstinent and is unlikely to go back to illegal drug use as she was concerned, among other things, to retain custody of her children. Unlike Wendy, none of the other women have been in treatment programs but nevertheless, they have moved on in their lives. For example:

Jade (27 years) now has a partner who is studying to be an alternative therapist. Her partner was abstinent following a heroin dependency problem and so she had tended to cut back on her own drug use for relationship and health reasons and is unlikely at this stage in her life to begin using a new drug;

Kit (25 years) had been undergoing counselling regarding repressed memory of a rape about 10 years previously and she has cut back on her drug use as she finds that it was not conducive to her counselling and recovery;

Gail, who is 24, now only uses marijuana but she has used speed and hallucinogens and would use them again if they were available and free, such as 'a present'. But, as she says, she mixes with a lot of '12 steppers' now and so is in an environment where drug use is discouraged.

Similarly, Kyra (24 years) and Melinda (23 years) both seem unlikely to begin heroin use at this stage of their lives. Both are studying at university, have used a range of drugs and have had access to a wider range, including heroin. Melinda states she is not 'into IV use'. Thus it not seem likely that either of these women will take up heroin use in the future.

There were 11 women who tried heroin but had not gone on to use regularly and over

half (7 women) had only tried heroin once or twice.

### Regular Use

There was no significant difference between women and men in the age in shifting to regular use. On average females began regular use at 19.3 years (sd=3.9) and males 19.4 years (sd=4.1). Regular use began among the ACT Drug Indicators Project population between 12 and 32 years. Table 6.8 shows the percentage on each age group for first regular use of heroin for both the ACT Drug Indicators Project men and women and the field study women.

**Table 6.8: Age of taking up regular heroin use**

Age Group	ACT Drug Indicators Project		Field study % Females (n=27) (1992)
	% Males (n=225) (1988-89)	% Females (n=111)	
12-13 years	2	4	0
14-15 years	10	14	0
16-17 years	28	21	22
18-19 years	22	23	33
20-21 years	13	11	19
22-23 years	10	9	7
24-25 years	6	11	11
26-27 years	5	6	0
28-29 years	1	2	0
30 years and older	4	0	7
Total	101	101	99*
Average age	19.4	19.3	19.2
Median age	18.0	19.0	-

\* Due to rounding the percentages do not total 100.

In the field study, 27 women went on to use heroin regularly, that is, at least once a week for some period of time. Except for Jay, all of these women had periods of dependency, mostly using heroin at least daily. A few of these women, such as Emily and Jay, had used at least weekly at some times but had found they were not dependent on heroin.

Sometimes every day but mostly only a couple of times a week. I would never say I've been dependent (Jay, 23 yrs).

Martha, however, described how she became dependent or to put it in her words 'got a habit'.

Regular use {of heroin} was about a \$50 taste every couple of days for about six months and I started having two tastes so it took to being about a year before I'd say it got that regular. Though two tastes a week after six months is probably a lot ... But I was in absolute control. .... I was working at .... and I was doing a lot of work very, very well. You know, it wasn't a big deal at all. .... I'd say 19ish to 20ish it started to become three times in a week and then I'd start to get scared and stop. But the fact that I was getting scared and stopping for a couple of days and then going straight back to having a huge hit made me realise that I was getting a bit out of control. I was still working. I was still doing massive amounts of exercise and I was still really quite together in other ways, but I was starting to get very intimidated by the fact that if I was scared, I thought about having a hit. That stuff. And then I'd think about and think

about it, and I'd say, "No, no, no, you're not going to have this. You're not going to," and then I'd go and do it. Just something goes ping, kind of like dieting, you know. Yes, that was about 19, 19 and a half to 20, so it became a real problem. (Martha, 33 yrs).

Martha relates that she combined a full-time job and a busy social life which included a heavy exercise program with her increasing use of heroin. Martha's pattern of developing dependency on heroin over a period of years was also common to other women.

I was 16 when I first used it (heroin), then I didn't use it again until I was 18 and, started off slowly, I'd use it once every few weeks and within six months I was using it, say, three times a week, then by the time I was 20, when I met my first real boyfriend, I was using it basically every day, then it was every day ... (Deidre, 25 yrs).

In this pattern which developed over a number of years, there was a period of experimentation, trying out the drug, followed by a period of irregular use, then more regular use (perhaps weekly) without dependency and then developing dependency which generally involved using daily.

A different pattern was evident among another group of women. It involved developing a dependency of daily use within a short time (around 1-12 months) after beginning to use heroin.

I sort of started using it every 2 weeks, or every month, I was, oh actually I'm proba-, pretty much went straight into it actually. I sort of replaced smack with speed, 'cos when I first started, I had such a big speed habit that if I had this much heroin it'd like... It'd cost me a quarter of what I was spending on speed anyway. And I'd feel really good, and then my tolerance f'smack built up (Selma, 22 yrs).

Well when I first introduced to it I got sick, vomiting and stuff, but then I just.. See L., my partner, the one I was with, the one that I am with, he was dealing at the time so it was there constantly and I just took {heroin} once but I didn't like it but I kept on going for it anyway and so I'd say, for about a year or six months, I'd use it but I wasn't addicted, I didn't have a habit, but then, I had a habit and I'd use it every day (Helga, 23 yrs).

Nevertheless, this did not necessarily mean that the women remained dependent on heroin. All of the women who had been dependent had moved out of dependency and sometimes back for a variety of reasons.

About 18 I started using regularly, I got my first habit when I was about 18. AND THEN YOU HAD A HABIT FROM THEN ON OR ...? No, not for the next 16 years, it was like there was times I went to rehab, times I went to jail, so I just had to dry out because my tolerance was too high and there just wasn't enough dope to feel it, so I'd have to dry out to get my tolerance back down. Yeah it was very off on, it was always the lifestyle where I'd be using it. Around that sort of people, leading that sort of life (Letty, 34 yrs).

Yeah, um, about, I dunno, 2, 3 months after the first time I had it, I started using regularly.... I'd go on huge binges of several months, and then have a break where I'd only take it like once a week, twice y'know, once a fortnight, and then I'd go on another huge binge, like every day, every second day (Karen, 19 yrs).

Interestingly, women in both Australia and America began regularly using heroin at the same age. In a study of women illegal drug users in New York City, Faupel and Hanke (1993) found that women began regular heroin use at 19 years of age, the same age as the women in the ACT.

## COCAINE

Among the ACT Drug Indicators Project group, use of cocaine began on average at an older age than for other illegal drugs. Age at first use ranged from 12 to 39 years with an average for first use of 19.7 years (sd=4) for females and 20.6 years (sd=4.7) for males (see Table 6.9). Although it appears that females began cocaine use at an earlier age than males, the difference was not statistically significant ( $t=1.49$ ,  $p=0.12$ ) and there was no significant interaction for age and sex. As occurred with the other drugs, there is a significant relationship between age of the respondent and age at first use of the drug with age at first use of cocaine falling by 0.48 years as the age of the respondent falls.

Similarly, Hser and co-workers (1987) found that, among the Californians in methadone maintenance treatment, cocaine use began at a later age than the other illegal drugs (except for phencycline (PCP) which is very rarely used in Australia). Anglo Californians, both males and females, began cocaine use at 22 years of age which is considerably older than the age the ACT women first tried cocaine. An early 1990s New York City study of women users of illegal drugs, however, found the average age at first trying cocaine was 18 years and that it followed heroin use (Faupel and Hanke 1993).

**Table 6.9: Age when first used cocaine**

Age Group at first use	ACT Drug Indicators Project		Field study
	% Males (n=186) (1988-89)	% Females (n=95)	% Females (n=34) (1992)
12-13 years	1	1	0
14-15 years	5	10	6
16-17 years	18	22	15
18-19 years	24	25	29
20-21 years	23	10	21
22-23 years	12	11	12
24-25 years	5	11	9
26-27 years	2	4	3
28-29 years	3	5	6
30 years and older	7	1	0
Total	100	100	101*
Average age	20.6	19.7	20.2
Median age	20.0	18.0	

\* The percentages total 101 because of rounding up.

In the field study, 34 women had used cocaine, one only once. Of the remaining 17 women who had not used cocaine, 11 were still between 16 and 19 years of age. Given the high average age for beginning to use cocaine (as shown in Table 6.9), it is likely that some of these teenagers will go on to try cocaine later in their lives. Only 27 per cent of the teenagers in the field study had tried cocaine, whereas 83 per cent of the

women over 19 years of age had done so. Availability of cocaine was probably the most common reason for teenagers not using. They simply had not had access to cocaine at this stage in their lives.

The women in the field study first tried cocaine on average at 20.2 years of age ( $sd=3.6$ ) with a mode of 18 years and range for first use from 15 to 29 years.

### Regular use

For those in the ACT Drug Indicators Project study, beginning regular use of cocaine occurred between 12 and 39 years of age. It appeared that there was a significant difference between the females and males in the age at beginning regular use ( $t=2.77$ ,  $p=0.007$ ) with the females beginning regular use of cocaine on average two years earlier than the males; females at 18.2 years ( $sd=3.4$ ) and males at 20.7 years ( $sd=5.4$ ) - see Table 6.10. However, an analysis controlling for age shows that the differences between the sexes was not significant. There was no significant interaction between age and sex.

**Table 6.10: Age of shifting to regular cocaine use**

Age Group	ACT Drug Indicators (1988-89)		Field study (1992)
	% Males (n=65)	% Females (n=32)	% Females (n=8)
12-13 years	3	6	0
14-15 years	12	13	0
16-17 years	19	31	13
18-19 years	12	22	38
20-21 years	14	6	13
22-23 years	18	13	0
24-25 years	5	9	25
26-27 years	5	0	0
28-29 years	5	0	13
30 years and older	7	0	0
Total	100	100	100
Average age	20.7	18.2	*
Median age	20.0	17.5	*

\* Not calculated because the small number of cases reduces the meaningfulness of the statistical calculations.

It should be noted that for women the mean age for first use is a year older than the mean age for beginning regular use (19.7 yrs for first use versus 18.2 yrs for regular use). As in previous instances, this anomaly is due to the group of regular users being a sub-group of all those who had tried cocaine. The mean age for first use for the sub-group of 32 women who reported regular use was 18.1 years ( $sd = 3.3$ ). Thus it is apparent that among the regular users, the women moved to regular use soon after first trying cocaine. Amongst the men, the mean age for first use for the sub-group of regular users was 19.9 years - on average there was a delay of a year between first use and regular use.

The Australian women in the ACT Drug Indicators Project sample began regular use at an earlier age than the women in New York City; the Australian women at a median age of 17.5 years versus 21 years for New York City women (Faupel and Hanke 1993). Erickson, Adlaf, Smart and Murray (1994) point out that even within one country there



are regional differences in the prevalence of cocaine use. Similarly, there are likely to regional differences in patterns of beginning use.

Of the 34 women in the field study who had tried cocaine, only eight had used regularly. Most could recall all the occasions when they had had cocaine as it was a once off or a spasmodic occurrence for most. Availability and cost were generally the explanations given for not going on to regular use. Unlike amphetamines, cocaine was expensive and not readily available for most of the women in the field study. Infrequent use of cocaine is more common than frequent use. General population surveys in the US document that cocaine is infrequently used. The US 1996 National Household Survey on Drug Abuse reported that 2.6 million people had used cocaine occasionally (less than 12 times in the past year) whereas approximately a quarter of a million people were frequent users (Substance Abuse & Mental Health Services Administration (SAMHSA) 1997).

Availability was a key factor for those who used regularly. Two of women had first used regularly when they were overseas and had a ready source of cocaine; Peg when she was in South America and Lou when she was in Japan working as a 'hostess'.

Well, I was working for the Mafia over there, and the bosses'd give us a lot of coke. Not crack; they would just give us coke and downers and tranquillisers, but they'd give us coke to sort of make us really happy all the time, like I was hostessing there, and occasionally they'd give us downers to help us sleep at night, or if we were too noisy, you know to quieten us down again, but mainly our bosses used to give it to us. And then we started buying it ourselves 'cos they weren't really giving us enough, you know, they'd give us a taste and that was it. And so I found my own dealer, that's where I got all the crack from (Lou, 30 yrs).

Two of the women who used regularly spoke of using cocaine and heroin together. Both May and Deidre mixed heroin and cocaine and injected it regularly. The majority of the women who were using regularly were either dealing themselves or involved with partners who were dealers and thus were able to obtain cocaine more readily and at a lower cost than women who were casual users.

## **SUMMARY - COMPARING MEN AND WOMEN IN BEGINNING DRUG USE (ACT DRUG INDICATORS PROJECT)**

In essence, the women were sometimes younger, or at least the same age as the men in the ACT Drug Indicators Project when they had started using a range of illegal drugs. The only exception to this was for cannabis. In particular, in the older age cohorts, men had tried cannabis at a significantly younger age than women. Patterns for beginning cannabis use follow the gender pattern that was common with the legal drugs. In those under 30 years of age, however, there was no differences in the age of initiation of cannabis.

The other difference of note relates to amphetamines. Amphetamines were the only drug where there was significant difference between the men and women in moving to regular use. Women shifted to regular use of amphetamines approximately one year earlier than males.

Table 6.11 summarises the differences between the sexes in the average age at first using a range of illegal drugs.

**Table 6.11: Average age at first using illegal drugs by gender and drug type**

	<i>Age at:</i>			
	<i>First Use</i>		<i>Regular Use</i>	
	Males	Females	Males	Females
Cannabis	16	16	17	16
Hallucinogens	18	17	18	16
Amphetamines	19	18	20	18
Heroin	19	19	19	19
Cocaine	21	20	21	18

**THE SOCIAL CONTEXT**

In this section, I use the data from the field interviews to compare the different social contexts such as the types of venues and companions for beginning illegal dug use.

***Companions***

The majority of women first obtained and tried all of the illegal drugs with the friends and acquaintances in their social circle (see Table 6.12). For example, in relation to cannabis, smoking ‘dope’ was clearly a social activity which frequently first occurred when sitting around with friends. This mode of introduction to illegal drugs contrasts to tobacco where a girlfriend or girlfriends were the most important source and companions for initiation into smoking but it is similar to alcohol where initiation began in a mixed sex social group. However, whereas with alcohol, most companions at initiation were school friends, by the time the women were beginning illegal drugs, their circle of friends was beginning to widen. School friends were still an important source for an introduction to cannabis but friends from other sources became increasing relevant as the women moved on to other illegal drugs. New sources included the friends met via school friends or work or university and they often formed a loose group of friends who used illegal drugs. Lisa, in explaining how she began to use amphetamines, tells a common story:

Yeah, that wasn't with school friends, it was a set of people I knew when I was at school... Ah, like I moved into a group house, ah, in that year, so it was like at my home (Lisa, 26 years).

In regard to heroin, three of the friends who were their source for first use were also their dealer for speed. Thus, a smaller minority of the women came to heroin use because of their contact with their speed supplier who also had access to heroin. Rhoda describes how she had her first taste of heroin from her speed supplier:

Well, when I was 25, the same person I was buying my speed off, was a heroin addict herself, and sh'never touched th'speed, so I useta sell the speed for her, and she useta score her heroin. And what happened was, that she gave it to me on a spoon, and just diluted it with a bit of water, and I drank it. And that was just a minute amount, and I sorta really liked the effect of that (Rhoda, 36 yrs).

Selma's introduction to heroin via her speed dealer resembles a common stereotype which exists regarding the introduction to new illegal drugs. That is, people move to new illegal substances because their dealer had run out of their drug of choice, and offered an alternative such as heroin.

I went to my speed dealer and he'd run out, and I asked him for a lift (in his car), and he rang up my boss and told him that I was too sick to come into work, and gave me some heroin n'I finally gave in, 'cos they'd all been saying oh, speed's really bad, speed's really bad fyou, and finally I decided to have some heroin, even though it was y'know, the taboo thing, I had it. And it was the best I've ever felt in my whole entire life! (Selma, 22 years).

Boyfriends were the second most relevant source for all drugs although for cannabis relatives such as siblings and cousins were equally important (see Table 6.12). The women who first used cannabis with their relatives generally began use at a younger age than those introduced by their boyfriends; 7 out of the 8 women who were introduced to cannabis by relatives were 14 years or younger when they first tried cannabis whereas 7 out of the 8 women who began using cannabis with their boyfriends were 15 years or older when they first used. Similarly, Rosenbaum (1981) found that a woman introduced to heroin use by a husband or lover tended to be somewhat older than those introduced to heroin in other ways. The older women generally began heroin use before 1970 (prior to second wave feminism), and they had little experience of group experimentation which was common with the younger women. For the women in the ACT, group experimentation with friends was the most common way of first trying illegal drugs. Most of these women began illegal drug use in the post second wave feminism era (since 1970) as occurred with the younger women in Rosenbaum's study.

**Table 6-12: Source of illegal drugs (column per cent)**

	Cannabis (n=51)	Amphetamines (n=46)	Hallucinogens (n=46)	Cocaine (n=34)	Heroin (n=38)
Friends	53	54	74	65	58
Boyfriend	16	17	11	21	32
Relatives	16	7	4	0	3
Girlfriend/s	10	11	9	6	8
Self	6	4	9	6	8
Can't remember/ missing data	2	7	2	6	5
Totals*	103	100	109	104	109

\* Percentages total more than 100 for some drugs because multiple responses were coded when there was more than one source. Percentages were calculated on the number of women who had ever used that drug (e.g. n = 38 for heroin).

**Setting**

Perhaps because of the sensitivity and secrecy associated with illegal drug use, the majority of women first used in a private place. Most of the women first tried all the illegal drugs in a home environment; either a friend's or relative's home or at or about their own home. Lisa's story about first trying amphetamines illustrated a common experience.

The next most common venue varied depending on the drug; for cannabis, it was a school, college or university setting but for amphetamines and cocaine it was a social occasion such as a party (see Table 6.13).

**Table 6-13: Setting for first use of illegal drugs (column per cent)**

	<b>Cannabis (n=51)</b>	<b>Amphetamines (n=46)</b>	<b>Hallucinogens (n=46)</b>	<b>Cocaine (n=34)</b>	<b>Heroin (n=38)</b>
Home/friend's home	37	37	74	41	76
School/college/university	20	4	7	0	0
Social occasions (eg party, folk festival)	16	30	4	29	0
Public venues (park/street)	18	0	2	0	0
Work	0	2	0	6	0
Country areas (national parks, by the sea, Nimbin)	0	0	7	0	3
Missing data	10	20	22	24	21

## CONCLUSION

Patterns for beginning illegal drugs use were quite different to the patterns for legal drugs. Whereas males generally began using legal drugs at an earlier age than females, the opposite pattern tended to occur for the illegal drugs. Females generally began using illegal drugs younger, or at least the same age as males. As discussed in the previous chapter, the social construction of gender, plays a part in the gender differences. The norms and values among illegal drug users for women's behaviour vary to those in the wider society. The constraints on women to be 'a nice girl, a good woman' are much less evident among illegal drug users because there is a competing emphasis on fun, excitement, risk and acceptance of breaking what are seen as outmoded drug laws

For cannabis the gender pattern for the age of initiation is mixed. In the older cohorts, males began using cannabis at a younger age than females. This pattern is similar to that generally occurring for legal drugs. Among those under 30 years of age, however, there are no significant gender differences in age of initiation of cannabis. As I argued in the previous chapter in regard to regular alcohol use, the social mores which emphasised greater restraint for women may be changing. Changing social mores, I have argued, can have occurred through contact with illegal drug users and would, in part, explain the narrowing of the gender gap in the age of initiation of cannabis.

Women who mix in illegal drug using circles are, in part, freed from the constraints of their sisters in the wider society as the norms and values of illegal drug using groups encourage fun and intoxication for both men and women (Dance and Mugford 1992) which provide alternative social values for women's drug using behaviour. This can partly explain the findings from this study that women generally begin illegal drug use as the same or younger age than men which are similar to findings of white Californian women in drug treatment. However, in both the ACT and California, males were younger than females when they first tried marijuana.

Changes in gender norms occur in piecemeal ways. Although most women in this study began illegal drug use via their friends, the second most common source and influence was a male partner indicating that the social constructions of gender in the wider community are still shaping behaviour in illegal drug using groups. Sexual behaviour is another area where different social standards have traditionally been accepted for men and women. The next chapter examines sexuality issues for women who use illegal drugs.



## CHAPTER 7: SEXUALITY AND STIGMA

Over the last decade, issues relevant to sexuality have come to claim a place on the agenda in drug treatment and research. One of the first developments was the recognition by women researchers and treatment workers that sexual abuse may be a factor in problematic drug use. Reed (1985) was one of the first researchers to suggest that 'incest and sexual violence may be important etiological factors in chemical dependency' (Reed 1985:31). Reed was writing about women's place in the drug treatment field and the barriers to drug treatment that women had experienced. It was not until some years later that other researchers began to recognise sexual abuse may also be important for a substantial minority of drug affected men (Rohsenow, Corbett et al. 1988; Howard 1991; 1992; Sibthorpe, Drinkwater et al. 1995).

At the establishment of the drug field in the 1940s (see Chapters 1 and 2), sexuality issues had a minor place in drug research as a whole (but a major place on research about women drug users). The change that has taken place over the last decade is that sexuality issues are now beginning to be taken from the perspective of the woman, what is important to her, rather than the perspective of others in that previously women were important in relation to others - or as the 'Other' (Irigaray 1985).

Women working in Australian drug treatment agencies have drawn attention to the importance of shame and sexuality in recovery (Women and Addiction Workshop 1987; Fraser 1994). In a review of the proceedings from the 1989 national Women and Drugs conference in Adelaide, Margaret Hamilton noted that women at the conference had felt that shame and sexuality were also important themes in the conference (Hamilton 1989). In relation to alcohol, Blume (1991) has argued that public perceptions associating female alcoholics with sexual promiscuity contributed to the stigmatisation of alcoholic women and may result in their physical and sexual victimisation. In addition, there are gender differences in how men and women manifest shame which create barriers to treatment for chemically dependent women (Gomberg 1988; O'Connor, Berry et al. 1994).

This chapter examines sexuality issues and shaming that arose out of drug using and sexual experiences of the women in the field study. The chapter is divided into four sections. I begin by examining the issues of stigma and shame in general and in relation to drug use and sexuality. In the second section, I examine beginning sexual experiences described by the women in the field study and explore the suggestion by some of the women that their drug use and intoxication was influenced by their uncertainty about their sexuality as desirable heterosexual women. The third section examines attitudes to women who are intoxicated and the ways the women dealt with these attitudes. In the fourth and final section, I examine stigma in drug treatment recovery including the responses to sexual shaming.

### STIGMA AND SHAME

Stigma involves the possession of an undesirable attribute that makes a person different from others of the category of persons available as his or her social group. But, as Goffman (1964) notes, not all undesirable attributes are at issue, 'only those which are incongruous with our stereotype of what a given type of individual should be' (Goffman

1964:3). Stigma, therefore, involves not only an undesirable attribute but also entails a special kind of relationship between an attribute and a stereotype of accepted social identity.

Society establishes the means of categorising people by standards of accepted social identity, which varies for each individual depending on gender, class, age, occupation and so forth. The stigmatised person tends to hold the same beliefs about identity as others in his or her social group but comes to realise that she or he differs from the stereotype of the accepted social identity (Goffman 1964).

(T)he standards he has incorporated from the wider society equip him to be intimately alive to what others see as his failing, inevitably causing him, if only for moments, to agree that he does indeed fall short of what he really ought to be. Shame becomes a central possibility, arising from the individual's perception of one of his own attributes as being a defiling thing to possess... (Goffman, 1964:7).

The stigmatised person, in recognising that he or she possesses a stigmatising characteristic may feel shamed. Some of those experiencing stigma may feel that their whole identity is tarnished because of a particular characteristic such as 'criminal', 'homosexual', 'addict'. Becker (1963) was the first to recognise that deviant statuses tend to exhibit a 'master status' quality. That is, that all other characteristics of the individual are subsumed and negated. The individual is responded to, first and foremost, in terms of the presumed membership of the devalued category (Schur 1984:24).

People come to recognise that they possess a stigmatising characteristic by both self-recognition and through the reaction of others (Page 1984:9). That process may be quite indirect. For example, a woman in a bar, upon hearing a drunken woman discussed and described as promiscuous, may come to realise that her own drinking could be perceived in a similar manner.

There are a number of responses to stigma recognition. Individuals may either accept or reject the assumption that a particular attribute is a cause for shame but they cannot ignore societal definitions. They cannot wish them away or remain unaware of them.

In recent years, some illegal drug users (IDUs) have explicitly rejected the stigmatising stereotype associated with the 'master status' of 'addict'. They have rejected the terminology of 'addiction' and use the term 'dependency' instead. Present and past illegal drug users have formed groups such as the national Australian IV (Intravenous) League and various state affiliated organisations which act as lobby groups and service providers (e.g. they run needle exchange programs) for IDUs. They recognise the societal stereotyping faced by all illegal drug users and they fight to dispel some of the myths that are part of the stereotype of 'addict' and 'junkie'. For example, at the 1994 National Women and Drugs Conference, women from one of the state organisation, the Queensland Intravenous AIDS Association (QUIVAA) challenged what they saw as 'the assumed consensus at the conference to silence' and ignore the expertise of women IDUs and to maintain the caricature of the women 'junkie', the dysfunctional addict (Women & Drugs 1995:7-8). Josie, who spoke at the final plenary session, rejected the all encompassing stereotype of 'addict' that occurs with a 'master status' stigma and emphasise the multiplicity of her character.



I am an IDU woman - and be it a challenging idea to many, I use heroin - simply because I like it...I am a parent and a friend. I was raised a Catholic. I played basketball and read books; even now I still read books. Mind you, I did drop the sport and church. Drugs are a small part of my life.....You cannot tell an IDU woman by the way she looks. Not all IDU women are in prison, or in crisis, or thieves or dysfunctional, or black or white. IDU women have strong spirits and survive, often against all odds, maintaining a sense of self (Women and Drugs 1994:8).

Acceptance of a stigma entails a quite different response. Acceptance generally involves some consensus between the subject and their audience concerning their lack of respectability. For some people, this can lead to secrecy. Some individuals such as ex-prisoners seriously consider changing their job, address or even their name (Page 1984:18). For others, acceptance is part of a process of moving to a more socially accepted status, by correcting the objective basis of his or her failing. But as Goffman (1964) notes 'where such repair is possible, what often results is not the acquisition of fully normal status, but a transformation of self from someone with a particular blemish into someone with a record of having corrected a particular blemish' (Goffman 1964:9).

Moving from being an addict to a recovering addict involves just such a process. Acceptance of oneself as an addict or alcoholic is the first step in recovery. The next step involves acceptance or even pride in the new identity of a recovering addict - a transformation of the self. The new identity, which may be attained via an understanding and acceptance of the disease theory, removes much of the shame associated with the person's past life as addict.

Shaming is a way of instilling conformity to prescribed social norms. But social standards change. For example, the shame associated with illegitimacy has declined substantially in Australia over the last few decades (Dalziell 1996). A sense of shame for certain proscribed activities is, nevertheless, acquired in childhood and helps to set limits to behaviour and is a normal and universal emotion (Lewis 1992). The development of shame is part of the process of maturation and is elicited by socialisation. A sign of maturity is the ability to feel and recognise one's own shame and then deal with the shameful experience. Lewis suggests that there are three general ways of dealing with shame - forgetting, laughing and confessing (Lewis 1992:10). 'Forgetting' involves putting the incident aside (e.g. putting a paper rejected by a journal into a little used drawer) and allowing the shame to dissipate with time. Laughing at oneself and confessing to a friend or a priest are also both methods to allow the tension associated with shame to dissipate. However, too much or too little shame can both produce difficulties and present problems not amenable to these solutions.

Too little shame has been related to the crime rate in modern society (Braithwaite 1989). People who are not integrated into a social network which is important to them are likely to feel little shame and so continue to commit crimes. Braithwaite argues that there are two types of shaming: reintegrative shaming which is helpful to both the individual and to society, and, disintegrative shaming, which involves stigmatisation and is harmful. Reintegrative shaming theory has been applied in the criminal justice system in dealing with juvenile offenders to induce shame in relation to the crime but in such a way as to not harm or stigmatise the offender (Braithwaite and Mugford 1994). The aim is to shame the offender by bringing the offender's family and/or significant others, plus the victim, to Community Conferencing, and so promote the offender to

feel shame about the crime but at the same time to show the offender that she or he is valued. Thus the offender is reintegrated with loved ones and via them into the community, not cast out as a deviant and criminal as occurs in normal court proceedings.

The effects of excessive shame have been shown to be crippling (Lewis 1971). Michael Lewis (1992) has examined the effects of shame on the self and pathologies of the self. Those people who are unable to develop strategies to cope with this intense and unpleasant feeling are likely to feel depression or anger instead of shame. They do this by 'bypassing shame', repressing the initial experience of shame and creating psychological barriers which repress or direct their feelings into other emotions such as depression or rage (Lewis 1971). Shame causes a disruption of thought and language (Lewis 1992:81) and the shame is internalised. Although shame is initially induced from outside, profound shame 'becomes the self judging the self' (Fraser 1994:134), and creates 'an inner sense of being completely diminished or insufficient as a person' (Fossum and Mason 1986).

Living in a shaming environment for a prolonged period (such as occurs in child sexual abuse) does the greatest harm. Responses to prolonged shaming include depression (a common response for women), rage leading to violence (a common response for men), suicide (violence to the self), and multiple personality disorder (MPD) which is the ultimate disassociative disorder. In MPD, individuals develop a coping strategy which allows them to believe that 'it is not me the abuse is happening to, it is someone else' (Lewis 1992:11) - it is another self.

Feminists in the alcohol and other drug field have argued that internalised and re-emergent shame is one cause of addiction, and that the shaming that occurs from racism and homophobia is one factor resulting in the high rates of chemical dependency found among indigenous people and homosexual populations (Fraser 1994:135). For men and women, there are different aspects of shame, particularly in regard to sexual matters. The differences are bound up in the social construction of femininity and masculinity, which includes an ideology of male control of sexuality (Holland, Ramazanoglu et al. 1991). Shame has been used to maintain control over women's bodies and sexuality in a way that does not occur for men (Fraser 1994:135). The same sexual behaviour which can be construed as a symbol of pride among men may be a source of shame in women such as promiscuity. For example, in a study of the social meaning of heterosexual relationships among young women aged 16-18 years, Wyn (1994) found that there was a propensity to label women 'sluts' and men 'studs' for the same sexual activity as was demonstrated in the following comment by a young woman from an outer urban area, who, when questioned if she would ask a boy out, said:

No, not usually, because guys get called studs and girls get called a slut. A guy can go to school on Monday and say 'I got on with six sheilas' and then a girl can go in and she'll be like this {indicating shame} because people will be saying 'you dumb scrag'. It happens all the time (Wyn 1994:35).

The young women's behaviour was constrained by their concern over their reputation. Even buying and insisting on the use of a condom was considered by some young women as a practice which would put them in danger of being thought of as 'a real slut' by boyfriends. Many preferred to take their chances with pregnancy rather than 'give

the wrong message to their men' and risk their reputation (Wyn 1994:35).

Similarly, women's alcohol use has been shaped by a 'double standard'. While drunken behaviour by either sex is socially condemned, it does not occur evenhandedly for men and women (Crowe and George 1989:382; Swift and Copeland 1996:16). Drunkenness among women is associated with sexuality in a way that does not occur for men. George, Gournic and McAfee (1988) have shown that a drinking woman is perceived by both sexes as less attractive, more sexually available, and more likely to have sex than a nondrinking woman. Furthermore, both men and women tend to excuse a drunken rapist and blame a drunken rape victim (Richardson and Campbell 1982). The film, *The Accused* depicts just such a scenario where a drunken woman, who has been 'gang' raped in a poolroom, later has a difficult search for justice in the courts.

Incest and child sexual assault also result in shaming and silencing of girls and women (Russell 1986; Fraser 1994). Feminist writers have stressed both the silence that women survivors have had to keep and 'the wider silence that has kept the nature of incestuous abuse secret' (Bell 1993:79). Drawing attention to and breaking this silence has been part of the feminist task.

Researchers in the drug field have shown that there is the high incidence of sexual abuse in the background of women who attend drug treatment agencies. In the United States, Wilsnack (1984) reported that the rate of incest and other child sexual abuse among women attending drug treatment agencies ranged from 12 per cent to 53 per cent, and was as high as 74 per cent for all sexual abuse combined. Later research reported a rate as high as 74 per cent for adult women in drug treatment (Rohsenow, Corbett et al. 1988). In Australia, a study of women in drug treatment in Sydney found that 47 per cent reported histories of child sexual abuse (Copeland and Hall 1992). In this study, I have addressed not only the sexual experiences of women who have been in drug treatment and also the experiences of others who use illegal drugs.

## SEX AND DRUGS

In this section, I explore the women's reports of their first sexual experiences which were quite varied. As teenagers, their experience of heterosexual intercourse varied from a wanted and enjoyable relationship, to insistence on giving way to intercourse, to coercion, physical assault and rape. One woman in the study said she 'had not had sex yet' (in other words, she was a virgin). Others suggested that their drug use and intoxication was influenced by their uncertainty about their sexuality as desirable heterosexual women. As will be demonstrated from the stories told by the women, their developing sexuality was shaped by attitudes and discourses learnt in the family, school, from peers and from a variety of cultural sources such as music, film and books.

In our culture, there are three meanings commonly attached to the notion of woman as a sexual being - virgin, mother and whore (Irigaray 1985). In Irigaray's representation of patriarchal heterosexual culture, there is no place for active female desire and sexual pleasure:

Neither as mother nor as virgin nor as prostitute has woman any right to her own pleasure (Irigaray 1985:187).

Irigaray takes as her starting point Freud's theory of sexuality which presents male sexuality as active and potent and woman as passively receptive. Other writers consider female sexuality to be more complicated. Hollway (1984), for example, has argued that there are several coexisting and potentially conflicting, contradictory discourses that impinge on sexuality and 'make available different positions and different powers for men and women' (1984:230). Only one discourse identified by Hollway relates to male activity and female passivity - the male sexual drive discourse. This discourse is widespread and is based on the tenet that:

'men's sexuality is directly produced by a biological drive, the function of which is to ensure reproduction of the species. The discourse is everywhere in common-sense assumptions and is reproduced and legitimized by experts' (Hollway 1984:231).

The male sex drive discourse comprises a constellation of quasiscientific rationales for masculine sexual aggression (Kippax, Crawford et al. 1990). Sociobiology, for example, would see men as having the urge to pursue and penetrate to ensure the continuation of their genes. Women, in the discourse, are represented as always receptive, even if they do not act accordingly. 'This attribution of a passive receptive sexuality simultaneously licences the man's unilateral action and interprets silence as the equivalent of consent' (Kippax, Crawford et al. 1990:538).

Hollway identifies two other discourses on sexuality, both which offer women some opportunity for autonomy in their sexuality: the have/hold discourse and the permissive discourse. The have/hold version of sexuality is based on a monogamous, heterosexual relationship, and is in accord with the stereotype of woman as wife and mother (but not a single mother). This version of acceptable female sexuality is a central tenet of femininity in Australia and elsewhere (Matthews 1984). A woman gains status and prestige on entering marriage and coupledness and, as a consequence, consents to the husband's sexual demands (Pateman 1988). In this version of female sexuality, the woman gains some bargaining power as the man commits himself to her publicly (Kippax, Crawford et al. 1990).

The permissive discourse challenges the principle of monogamy. It is based on the premise that '*both sexes ... have a right to express their sexuality in any way they choose as long as nobody is hurt*' (Hollway 1984:234 - emphasis in the original). In theory, it is a scenario of equalitarian sexuality (Kippax, Crawford et al. 1990). But the discourses discussed do not operate separately. As Hollway notes: 'The difference between men's and women's positions in the traditional discourses were never banished by permissive practices' (Hollway 1984:235). The discourses overlap and are historically situated. The permissive discourse is a product of the 1960-70s 'sexual revolution' and was, in part, an affirmation of autonomous male sexuality and promiscuity (as many in the Women's Movement came to recognise), and an offspring of the male sex drive discourse (Hollway 1984:234-5). The danger of being labelled a whore or a slut are still present for women despite the permissive discourse (Kippax, Crawford et al. 1990; Wyn 1994).

All of these discourses about the social construction of female sexuality shape and inform girls as they reach puberty and are beginning the process of becoming a sexed adult. In examining drugs in relation to sexuality, I do not intend to argue that young

women's sexuality is passively produced by some form of patriarchal power relations. Rather, the young women are actively engaged, in varying degrees, in constructing their own femininity and sexuality, despite generally being in situations in which they lack power and a discourse through which to assert their own desires.

### ***Youthful drug use and sexuality***

For many adolescents, beginning drug use was part of the excitement and fun of growing up, a marker of the transition to adult status. Becoming sexually active is also part of this process (Jessor 1987:334-335). For girls, developing and constituting themselves as sexual, attractive women is a central subject position in becoming an adult (Hollway 1984). Martha and Peg spoke about these experiences in relation to their drug use.

And I still don't think the drug use was a problem for quite a while after that either. I think my youth was the problem....So, it must have been about 19 that it really started to hit me. I realised that I was very juvenile around sexuality, around what my needs were.... You know, I was partying and I had no concept of getting older. You know, you're, know you're beautiful. Your world is full of fun and excitement and you shoplift and you do all these absolutely immoral things that you're not allowed to do and you don't care because the most important thing is having boys look at you. Being looked at (Martha, 33 yrs).

I started taking speed basically because I was a very shy teenager, and I guess that is a fairly common story. At the time, I didn't think I was attractive and was awful and all these things. And when you take speed, you can drink endlessly and sort of, and the two drugs, kind of, you can drink more and appear more sober, so it is a real good way of getting along with the lads or the girls (Peg, 26 yrs).

Peg and Martha were at different stages of constituting themselves as sexually desirable women and for them, drugs were part of, or assisted in the process of being desired and wanted, as becoming or being women that other people wanted to be with or considered attractive<sup>25</sup>. A sense of anticipation, fun and excitement in regard to sexual relationships and drugs, particularly when first trying a drug, was common when a teenager but was less common once the women were older. The teenagers were trying out their new found independence, experimenting with relationships, their sexuality and with drugs. All of these activities are tinged with excitement, pleasure and at times some danger. Sometimes the experience went wrong and it was a source of discomfort or even at times pain. But, despite the occasional bad experience, the anticipation of pleasure in relation to drugs was a common discourse among the young women and fits within the pleasure model of drug use described by Mugford (1991).

The women had a different conception of what they wanted from a sex experience to the men in their lives. For example, Nye spoke about an early sexual experience when she was 15 which she did not find satisfactory.

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<sup>25</sup> Now having passed their mid-twenties, both have matured into confident women, happy with their sexuality. Neither Martha or Peg became dependent on drugs, although both have used drugs regularly (heroin for Martha, speed and cocaine for Peg) for some periods in their youth.

Yeah, but I was, that person actually got me drunk for that reason.... Oh, I get really pissed off at the person 'cause I'd seen him do it to heaps and heaps of young girls, like my friends and stuff and it just got me really angry... and like with me it was sort of he had sex with me and then went to sleep and didn't even talk or anything, I like talking, I don't like just sex, I like the sharing, I don't know really enjoy the sex in, oh there's two ways of sex, sex as a whole big thing... I like things like kissing and hugging and stuff like that, not just sex (Nye, 16 yrs).

Similarly, Martha, who spoke above about her awakening sexuality when she was 19 years of age, had previously participated in sexual intercourse. But it was not a pleasurable sexual experience for her. In response to my question: *Have you ever felt pushed into having sex when you didn't want it?* Martha explained that she:

just wanted some affection, didn't know about having sex, didn't know about orgasms. Just did it to be wanted... Both using drugs (Martha, 33 yrs).

Being coerced into sex, particularly when a teenager, was a common experience among the women. Nearly half (45%) mentioned episodes of being pressured into sexual intercourse when they were teenagers, some when they were as young as 12 years of age. At this age, many were passive and had no way of resisting unwanted sex. They were vulnerable to the male sex drive discourse which ignores female sexuality and autonomy as non-existent. Thus, for many of the those in their early teens, men's sexual 'needs' are accepted and not challenged. Gail, who has since recognised she is lesbian, describes her experiences of unwanted sex.

Hmm. Yes, with boyfriends, just feeling like it was expected, but feeling really uncomfortable about saying no... We probably both were (drunk), or maybe he was and I wasn't (Gail, 24 yrs).

Both Lily and Trixy were coerced into their first sexual intercourse at a young age, Lily physically and Trixy verbally.

I was very young, only about 12 or 13. I went to a dance, and I suppose I was raped... Yeah, we (my girlfriend and I) ended up going home on the train with these boys, and when we got to their station he pulled a knife and said "You're getting off the train". I mean there wasn't a big fight or anything, but I was too scared to do anything else. I don't think I ever talked to anyone about it. I think you're probably the first person I've ever told. Oh, I've mentioned it, that my first sexual experience was forced, but that's as heavy as I've even gone into it.... I tend to minimise stuff like that (Lily, 39 yrs).

...with my brother's friends, when I was about 12, 13, sort of about their age, and just giving no rest and hassling me and I was young and let them get their way... I was just, I don't know, you know how it is when you're that age, you know. So they gave me (you're) a frigid bitch, you know, that sort of stuff... Yeah, maybe about the age of 14, I was mostly over that I think, no problem. There was probably a couple of times after that between the age of 14 and 16, where I did, probably slept with a couple of people I didn't particularly want to but wasn't like when I was young (Trixy, 26 yrs).

Although Trixy's first sexual intercourse was not associated with alcohol or other drugs, this was not so for the other women. Nearly half of the women reported similar episodes of unwanted sexual experiences in their mid-teens but the occasions were associated with alcohol or illegal drugs.

I think when I was 16 and there was a fellow there that, we'd sort of grown up together, and he was working for dad as well, he was two and a half years older than me and he sort of took me under his wing and said you know, I'll take you out and look after you and things like that, and both times, twice with him, and we'd go out to the club, this club in Narellan, and there would be guys a lot older than him, bikies and things like that, they'd hang around at the club, and they'd be all buying me drinks and buying me drinks and then I'd have to go outside for air and both times with him it was sort of like we didn't want to but I felt you know that I had to, and that was sort of with alcohol... Yeah, he was drunk as well. Yeah... like I remember, I still remember thinking I have to go home, if I don't go home with him and his brother I'll be dragged home by these bikers, so I had to do what I had to do so I make sure that I'd get home. It was weird (Cissy, 29 yrs).

Just when I'd gone out and if I'd been flirting with a guy, I just couldn't stop it.... I used to hate being poked. I just couldn't be bothered. I get sick of saying no. I said no, go away. (Describing the interchange) You can't say no to me! NO! They don't listen anyway (sighs).... It was just like a Friday night thing. Have a few drinks and got onto some...(Vivienne, 19 yrs),

Just basically both people are under the influence of something and, I don't know, just sort of didn't really want to but didn't do anything about it. Just sort of, it's hard to explain.... I don't really want to but it's too much hassle, to think about it or explain that to him (Renata, 16 yrs).

It could be argued that being under the influence of a drug was a way of excusing casual sexual intercourse. That is, as adolescents, they are interested in becoming sexually experienced as a part of becoming adult but, as girls, they also fear being maligned for being sexually active, and being intoxicated provides an excuse for behaviour that could label them as 'bad' girls. However, on the whole, young women who use illegal drugs don't see themselves as 'goody-goodies' and the discourse about 'nice girls don't' did not serve to stop their rebellious behaviour with drugs and sex but simply to silence them when their behaviour led to sexual assault. Silencing about sexual assault was common when teenagers. Angela tells how it happened for her.

I was about 17, that's when that happened.... I'd taken off from m'parents' place, n'went drinking with a girlfriend, n'we decided to go to this carpark. And that's where it happened, in a carpark. Actually there was two of them, more than one, yeah, n'I just left myself in a really vulnerable situation. She took off with somebody else, n'I just stood around by the car, not even thinking about the danger that I was in.... And actually somebody else reported it, and this policeman just lived over the road from us. And he came over that night and asked what had happened, and I lied and said that nothing had happened, 'cos I was really worried about what my parents'd think. And then my periods were late, n'I ended up telling my mother, and she was really angry at me. Yeah, she couldn't cope with anything like that, she'd think that always, if something had happened to me it was my fault, which it was or I shouldn't've been in that situation (Angela, 36 yrs).

As adolescents, girls are faced with contradictions as they explore, create and negotiate their sexuality (Kippax, Crawford et al. 1990; Wyn 1994). There are conflicting and multiple discourses concerning women as sexual beings. Some discourses such as being sexually attractive which involves learning and presenting certain images of dress, body shape and behaviour (Bordo 1989) are explored with some pleasure (Hollway 1984). But others are a much greater source of conflict. Girls walk a fine line: they must be seen as sexually attractive but not disreputable (Lees 1993). But being the

object of desire sometimes lead to unpleasant consequences, as those in their early teens had no way of articulating, much less demanding that their own pleasure be taken into account. Thus, at the time, they had no way of articulating their discomfort with unwanted sexual intercourse, although with time, many were able to do this. Janice's recollections clearly demonstrate this change.

Her first intercourse occurred when she was 12 years of age and in her teens she had problems dealing with coercive men. By the time she was in her twenties, she had rejected the discourse that sex was the expected outcome of a 'date' and developed a way of making this clear.

I was raped when I was 14 by three men who were all pissed, that was the situation. And then I had a few situations and I can't really remember dates of things but basically, you know, you go out with someone and then it's, oh, have sex with me, I've taken you out for the night, or else I'm not gonna take you home and we lived in the country, so I needed a lift home, so it was a quick fuck in the back of the car because, and usually no contraception that they bothered with, but I was on the Pill..... And then I went away and went off and lived elsewhere and went to HSC (final 2 years of secondary education) but that was still sort of, having sex when I didn't really really want to, but, oh, yeah, well you know, it's just easier, rather than arguing about it and yeah, you know. Girls get pushed into these things.... if someone wants to take me out now I just say, yeah, I'll go out, I'll go out for cocktails, I'll go out for dinner but I won't fuck you and I just say it blatantly and then if they say, well, don't like you, well we don't go, but if they say, well, yeah, that's fair enough and we do go and it's alright and it's all laid out on the line beforehand, and nobody knows any different. So that's quite good stuff (Janice, 29 yrs).

Janice was only able to express her desires and obtain her desired outcome from a casual sexual encounter when she had gained the confidence and the language to negotiate. Holland, Ramazanoglu, Sharpe and Thompson argue that 'a young woman can only assert her sexual needs in terms of her own bodily pleasure if she can negotiate sexual boundaries with her partner' (Holland, Ramazanoglu et al. 1991:2). In negotiating, Janice presents as a sexually knowledgeable woman which is quite different to her earlier part as the silenced woman in the male sex drive discourse. She had learnt a different way of asserting her sexuality. Similarly, Rhoda had first accepted that men's sex needs were paramount and did not realise that she had a right to insist that her feelings be taken into account in a sexual relationship:

wouldn't take no for an answer..... 'Cause when I was growing up, m'sister D led me to believe that sex was dirty. And then I believed that that th'done thing that a woman had to do: they couldn't say no. And when I actually had a relationship with someone, the guy wouldn't take no for an answer; like it was an expected thing, of me. And I never knew any better. So I just never said no.... And I got told by other women, that you just don't have to say yes; you can say no, it's okay (Rhoda, 36 yrs).

Even though Rhoda was in a monogamous heterosexual relationship, the type of sexual relationship derived meaning from the male sex drive discourse which she had learnt from her sister in whose house she had been raised, and that meaning was later re-enforced by her male partner. It was not until she was in a women's group in drug treatment that she had learnt another acceptable way of asserting her sexuality and so had the opportunity to negotiate in her monogamous relationship.



Some of the teenagers were able to confront the hegemonic discourse of male sexuality and assert their desires. A minority (18%) of the women had never been pushed into unwanted sex. In comparison, Wyn's study of 95 women aged between 16 and 18 years found that only 11 per cent 'had had sex against their will (1994:36). The reasons for the large differences in the two groups is not readily apparent. There are three possible reasons associated with characteristics of the illegal drug users in my study who had not been coerced into unwanted sex. Compared to the other women in the sample, they were younger, more assertive and sexually confident, and they had been wise or lucky enough to associate with the right men - men who would accept no as an answer.

Because they were younger than the other women in the sample, they had less opportunity for sexual experience and so less opportunity to encounter a situation of coercive sex. Seven of the minority group of nine were under 20 years of age and they constituted almost half of the under 20 years olds in the sample. All of minority group were under 25 years of age. Similarly, the women in Wyn's study were young, being between 16 and 18 years, and so, they also had limited experience. Nevertheless, many of the women in my study who were subjected to unwanted sexual intercourse had experienced it as young women - under 18 years of age. But as was noted above the others differed in two other ways. Sabina demonstrates the characteristics in her response to the question if she had had unwanted sex:

Well, no, and I think I'm really strong with that sort of thing, 'cos I noticed lotsa times, like before I lost my virginity, that guys'd wannit, you know, sex, but I'd always just say no, a'that I didn't really have a problem with it, as far as I can remember, they would always be quite good about it (Sabina, 17 yrs).

Not only was Sabina assertive in making her sexual wishes known, but she also mixed with men who accepted her wishes. In contrast, some of the other women in the study had been faced with men who had no such scruples - men who committed rape. Jewell was another who was successful in asserting her sexuality in part because she mixed with the right boys who:

understand me, at least to the extent that you know me, if I say "No", they'll go "okay", I mean they might go "Nnnhhh" but that's it, they know (Jewell, 17 yrs).

Nevertheless, Jewell's ability to avoid unwanted sexual experiences was due in part to her confidence in her sexuality. She turned down propositions because she valued her body and sex was 'sacred' whereas other women who were more in need of affirmation were prepared to tolerate unwanted sexual intercourse in exchange for feeling wanted and desired. All of the nine women who had been able to avoid unwanted sex used illegal drugs without problems - at the time when I interviewed them, none had ever sought help for their drug use.

Women who had been subject to child sexual abuse were much more likely to have attended a drug treatment agency. Nearly a quarter (23%) of the women in the field study had been sexually abused as children but only half of this group had ever attended a drug treatment agency.

In summary, sexuality issues are important to many women who use illegal drugs, not only those who consult treatment agencies. Those who had been subject to child sexual

abuse were particularly vulnerable to the male sex drive discourse, both as children and as adults. But they constituted only a quarter of the sample. In exploring adult activities, trying out drugs and sexual relations, almost all the young women had been faced with the dominant discourse of male sexuality, and many, due to lack of confidence and lack of a discourse to assert their desires, acquiesced to unwanted sexual intercourse, and others were subject to rape. Because of the sexual 'double standard' many, at first, were silenced and unable to talk about their experiences. They were shamed into silence. With growing maturity and confidence, most picked up on other discourses which helped them to assert their desires in sexual relations. Only a minority, less than twenty per cent, had sufficient confidence when they began trying illegal drugs that they were able to voice their sexual desires, and for these young women, both sex and drugs was a source of excitement and pleasure. The 'double standard' was also present in relation to drug use and the next section examines the women's experience with the attitudes of the wider society and those in illegal drugs using groups to women's drug use.

## DEALING WITH STEREOTYPES OF WOMEN'S DRUG USE

A common attitude found in the US is that women who are intoxicated are promiscuous and are available as willing sexual partners (George, Gournic et al. 1988; Blume 1991). In this section, I examine the attitudes that the women encountered as a result of their drug use and how they dealt with the social responses to their drug use.

Most of the women in my field study had confronted a double standard that labelled women who are drunk as disreputable. However, 'heavy drinking' among men has frequently been regarded as a symbol of toughness and rebellion (Jarvis 1992) and a sign of masculinity and glamour (Becker 1963).

In response to my question: *Do you feel society looks down more on men, or on women, or is it about equal, who are drunk or stoned?* none of the women interviewed felt that society looks down more on men who were intoxicated than they do women. Some (9%) felt that the stigma was about equal but the majority felt that greater stigma fell on women, particularly in relation to alcohol and drunkenness.

Things like having a few drinks is OK for everybody. Getting rat arse blind isn't OK for women. Particularly like, if you look at social occasions where it's almost mandatory to drink, say like at a wedding, everybody expects the father of the bride to get incredibly sozzled, and if he falls over, everybody laughs. If the mother of the bride does it, people will react with horror (Tara, 27 yrs).

And later in response to the general question about what behaviours are not OK for women in Australia today:

I suppose most of the things that I have found with women ...which aren't OK for women has to do with the level of intoxication (Tara, 27 yrs).

And another woman, when asked if she could give any examples of things said to her when drunk or stoned, offered:

I've got hundreds. Where do I start?.. I remember when I was stoned one time and someone asked me, actually saying to me, yelling out something to me from this group of men, and I told them to get lost and they'd say, "Well, your asking for it!" I was stoned but I wasn't completely too stoned and this guy yelled out something like, "Do you want a f..." and I told him to get lost or something. ..Yes, another time, I remember going to a pub one night and it was really amazing.... I remember having a beer outside with someone and being a little bit drunk, but not very drunk, and this fellow came to me, "You won't find a lay out here" ..But it was very, it was like ..you can't be female and be drunk (Martha, 33 yrs).

For women, intoxication had the added stigma of being sexually disreputable. Some women also felt that drug dependence among women is further stigmatised by an association with sexuality. Discussing the stigma associated with drug dependency, one woman argued:

I think there is very little, by comparison, there's very little stigma against men. Against women, yes. And I think, I think a lot of that's actually got to do with, well, part of how women are perceived when they're drug dependent, particularly with heroin as against alcohol. They fall into the category of "bad women" and to me that category of "bad women", no matter why you're there, there's a whole bunch of things here - that you're an easy lay, that you've got no self respect, a whole range of things and a lot of them are sexual things. You're considered to be cheap, if you like, not like other women (Tara, 27 yrs).

Nevertheless, some women clearly resist this stigmatisation. For example, Tara felt that men's derogatory behaviour towards drunk women was more a reflection on the men.

One of the things I find unbelievably grating is when a woman is drunk to the point of having passed out, that is if there is a guy there who happens to be a sleaze bag, that won't stop him fucking her. And I just find that so utterly repellent. It's completely vile. And some men, it doesn't matter how they get sex, it doesn't matter if they get it by badgering you for hours and hours and hours so you say, "All right!", sex is sex is sex. It doesn't matter how.

Margaret took a more active form of resistance. She spoke about a time when she was really 'stoned' and was pressured into sex. She had said no, but in the end it was easier to do it. She says:

I was really stoned ... I had sex ... and then I wanted to get rid of the humiliation. I rang him up, and this is six years later, I said to him, "You were really bad anyway. Took five minutes. I don't think any woman's ever come with you, and good on you, that you're so sexy you have to get women really stoned. Whoopee." ... I thought "F... it! I'm not wearing this shit and this is what you have to do. You have to give it back to them."

Some of the women reported that they saw less stigma towards intoxicated women when they were with their circle of friends (i.e illegal drug users) than they found in the wider community.

like when I was at college and stuff like that, a big bravado thing it is, for men to go out and drink together, y'know; whereas women are sort of considered pathetic if they can't handle themselves, and men are kind of funny. And, um, I don't think that's an attitude amongst, necessarily amongst my friends, but in terms of the general population who're just going out into Civic and watching the behaviour at the nightclubs, and it's all like that, you know. I mean I think that men probably secretly like it when women get drunk, because they, then can get them into bed and anything else, but I don't think that they consider them, um, I think they look down on women more than they, men look down on each other getting drunk (Emily 19 yrs).

However, there are different groups of drug users as Selma makes clear. Some illegal drug users who are part of the criminal element exhibit sexism.

I think among straight people that drink, that would happen: they'd look down on women ....., not among drug users.... Well, there's guys that think that women that get out of it are just, are sluts. .... Not my group of friends, no. And also there's a like, guys who've been to gaol quite often think that women're just stupid whinges and you give them drugs. But that's a different thing, once again (Selma 22 yrs).

Thus, women who use illegal drugs experience different social attitudes to their drug use depending on whom they mix with. Among the general population, their drug use is seen by many others as marking them as 'sluts' and sexually available. Among some illegal drug users, however, drunkenness and use of illegal drugs is a source of fun and rebellion against the wider society for both males and females and so women suffer little stigma in these groups. However, a number of women who mixed with men who had been brutalised by a time in gaol found that those men particularly derogatory towards women. Many women were silenced and shamed by sexual stigma but others, with growing confidence rejected the stigma.

## **SHAME IN DRUG TREATMENT RECOVERY**

Shame is an issue in recovery from drug dependence for both men and women. As was discussed previously, the disease theory of addiction provides a way in part of dealing with an 'addict' past behaviour. In addition, organisations such as AA and NA provide a way for recovering addicts to tell their story in the group which is a type of 'confessing' and deals with past shame. Similarly, people who consult counsellors have an opportunity to tell of shameful experiences and so address past shaming.

Ettorre (1992) argues that traditional self-help organisations such as AA and NA do not challenge the traditional social construction of gender. They focus 'on individual enlightenment rather than group consciousness' (1992:133). They 'are mixed setting' which 'do not provide the optimum environment for women of varying ages, sexual orientations, social classes and ethnic origins to empower themselves' (1992:134). Thus, traditional self-help groups provide women with no way of addressing sexual shaming. Young (1990) has suggested that 'addictive behaviors may serve to defend against memories of child sexual abuse', and therefore must be considered as a possible component contributing to relapse to addiction. Drug treatment services have begun addressing incest among their clients and so have also addressed shaming and post-traumatic stress disorder (Goodwin 1985; Fraser 1994). Putting sexual matters on the agenda in drug treatment has also resulted in women's groups which allow women to

address sexual shaming issues and provide different discourses to address sexual experiences. Feminist drug treatment agencies articulate an alternative discourse which allows for group consciousness raising on the social construction of gender and may be the reason that they are more successful in attracting survivors of child sexual assault than traditional drug treatment agencies (Copeland and Hall 1992).

Incest is also a cause of relapse among men. A study of men and women attending an inpatient chemically dependency program in Maine found that the incidence of child sexual abuse among adolescent men was 42 per cent (Rohsenow, Corbett et al. 1988), and they argue that failure to address child victimisation can contribute to relapse among both men and women. Men who were victims of child sexual assault are shamed and silenced to an even greater degree than their female counterparts and it has only been since these issues were recognised among women that it has been possible to start addressing sexual assault in drug treatment for men as well (Rohsenow, Corbett et al. 1988).

Nevertheless, as my study has shown, not all illegal drug users have to deal with shame by treatment and group consciousness raising. A number of women in this study, with developing self confidence, rejected sexual shaming to which they were subject. Martha and Tara, two whose stories demonstrated their self confidence and rejection of shaming, were also two who rejected the disease model. They found an alternative way of dealing with shaming associated with their drug use.

In the following and final chapter, I draw together the threads of the social construction of gender as it relates to illegal drug use.



## CHAPTER 8: SUMMARY AND CONCLUSION: CONSTRUCTING THEORIES ABOUT DRUG USE AND TREATMENT

Understanding the history of theories of drug use and treatment for chemical dependency helps illuminate the present state of knowledge in the drug field. In each era, drug treatment and theory has been shaped by the social forces of the times, and the historical background shapes our present understanding and practices. The disease model, a major theoretical development in the drug field, marked the beginning of attempts to situate drug dependency in a medical and scientifically based treatment. But as has been shown by critics of scientific knowledge, changes in scientific theories and methods are not exempt from social influences (Kuhn 1962; Wertheim 1995). Nor do developments in medical practice arise from a value-free science. They are partially shaped by social factors and struggles for power among health professionals and others (Willis 1983; Cheek, Shoebridge et al. 1996). The rise of the disease model of addiction was a product of its times in two ways: first, it contributed to the medicalisation of social problems; and second, it obtained scientific legitimacy for the drug field, in part, by Jellinek applying a scientific methodology (an empirical study) to explain alcoholism.

Furthermore, as in other fields of social scientific endeavour, the study of illegal drug use has, until recently, principally been the study of men's lives (Kalant 1980; Broom and Stevens 1991). The changes over nearly two decades (see Chapter 1 and 2) which brought women more into the picture and addressed gender issues, have been informed by the contemporary women's movement. This thesis, as have others texts on women and drugs (Ettorre 1992), draws on feminist theory, in an attempt to understand how gender shapes knowledge about the present construction and practice in drug use and treatment regimes. Thus, in itself, this thesis and other developments in gendered drug studies are also shaped by the social context of the times.

Recognition of the social construction of medical and other knowledges does not deny that it can be desirable to have, for example, well tried and tested drugs and procedures (Cheek, Shoebridge et al. 1996) based on sound empirical methods such as the gold standard of medical research - the randomised controlled trial. But social constructionism reminds us that at the very least the original hypothesis that precipitates research arises from a particular social and political milieu. Exploring the gendered nature of drug theories and treatment demonstrates how the taken-for-granted assumptions about men and women in society were incorporated in drug theories and treatment practices.

For example, the career model as developed in the 1960s depicted an alternative occupation in heroin using and dealing for young men who had no opportunities for a legitimate career or even a meaningful occupation in the underclass slums of the large US cities. Women were largely invisible in this early model as, at the time, the taken-for-granted assumptions about work and gender placed men's careers in the public working world and women's main occupation in the private sphere, as homemakers and mothers. Thus, the normative form of gender of the 1960s was incorporated into the drug career model which assumed that a drug career was irrelevant to women. It was not until the 1990s, when Taylor (1993) explored the experiences of women using illegal drugs in the working class suburbs of Glasgow, and drew attention to the fact

that drug using and dealing also provided a meaningful way of life for some working class women. Even though many of these women had dual responsibilities as mothers, a drug career provided an attractive alternative to the stresses of mothering. Nearly a decade earlier, in one of the early feminist studies of women in drug treatment, Reed (1985) had noted the importance of job skills and career training for women as well as men in drug treatment programs. Taylor's research applying the career model for women supplies data and a theoretical argument supporting Reed's intuitive plea to provide job training and job opportunities for women as well as men.

Similarly, the mode of practice arising from within the disease theory (such as AA practices) is influenced by the social construction of gender - in this case the nature of hegemonic masculinity. The confrontational techniques in disease model programs grew out of the need to break through the tough outer shell of denial - denial of a problem with drugs, and denial of weakness which is a characteristic of the hegemonic ideal of masculinity - the tough, strong man. Disease model programs began with mainly male clients and so developed methods of dealing with the prevailing forms of masculinity. But, as has been argued in Chapter 2, an examination of different constructions of gender suggests that the confrontational technique can be counterproductive to some types of subordinated masculinities as well as many women.

Furthermore, although the male culture in AA deals with shame associated with addiction, it was also a reflection of the male culture of the wider society which had ignored and silenced women who were shamed into hiding experiences of childhood sexual abuse, sexual harassment, assault and rape. It was not until the discourses, or discursive frameworks from the women's movement were taken up in the drug treatment field that women were able to voice their discomfort and deal with the shame associated with sexual abuse which related to their drug use. Women speaking out about sexual abuse and coming to terms with all their shameful past experiences, not only their addiction, has placed sexual abuse on the agenda for drug treatment agencies and permitted survivors of sexual abuse to deal with the secret demon and so reduce the incidence of relapse, the impulse to use drugs to suppress the shameful experiences. In turn, women's speaking out about sexual abuse has provided a window of opportunity for an even more shamed and silenced group, men who have been sexually abused, to voice their distress and seek help as part of dealing with their chemical dependency (Rohsenow, Corbett et al. 1988; Bammer 1993).

Thus, a gender analysis of drug treatment and theory helps in uncovering the social construction of knowledge in the drug field and leads to improved treatment options for both men and women. In this research, I have not examined the differing impacts of gender in all drug treatment modalities but have taken some specific examples to demonstrate how the social constructions of gender are encompassed in drug theories and the treatment options arising out of the theories.

Further, I have argued that the pleasure model of drug use is improved by considering it in the light of gender. Although the pleasure model has little application to drug treatment, understanding the pleasure discourse in drug use would help in planning preventative drug programs. But women's pleasure seeking is more complicated than men's, principally because of the sexual double standard in the general community. Girls are subject to more social sanctions for promiscuity and intoxication than are



boys. In addition, it should be noted that not only has drug use and treatment been shaped by social forces but also the epidemiological methods associated with measuring and estimating illegal drug use in the general community.

## **EPIDEMIOLOGY**

Data collection and analysis using scientific, epidemiological methodology is often thought to be value-free and gender-neutral. The advantage of epidemiological measurement of illegal drug use employing indicators to measure the level and nature of drug use is that it has always been recognised that each indicator has strengths and weakness inherent in the method of collection. Consequently, researchers have used a number of indicators to develop the best estimate of changes in illegal drug use (Person, Retka et al. 1976; Commonwealth Department of Community Services and Health 1988).

However, there has been little research which has made gender comparisons of the drug indicator data. Comparing the indicators of drug use for men and women in the ACT Drug Indicators Project shows that the drug treatment results are somewhat different from the indicators derived from the drug arrest data. I have argued that the masculine culture of the criminal justice system and the taken-for-granted assumptions about appropriate behaviour for men and women in the general community lead to different police management of men and women in relation to drug warnings and charges. The result is drug arrests data that minimises women's cannabis use and distorts the sex differences in illegal drug use in the wider community. Given that arrest data form an integral part of illegal drug indicators both in Australia and elsewhere, it is useful to recognise the gender biases in the data in estimating gender differences in the population at large.

## **GENDER IN BEGINNING DRUG USE**

The social constructions of gender shape patterns of beginning drug use for males and females but in different ways. Males begin smoking tobacco and drinking alcohol at a younger age than females. I have argued that these gender differences are informed by gender-specific norms which constrain girls more than boys. Traditionally, in Australia and elsewhere, femininity has been associated with being a 'nice girl', a lady or a 'good woman', and in the past 'nice girls' didn't smoke or get drunk. By contrast, positive masculine images have been associated with drinking and smoking. A symbol of manhood has been the ability to 'hold your liquor'. But gender norms are changing, including the taboos about women's use of alcohol and tobacco. One consequence is that the gap between males and females in age of initiation for cigarettes and alcohol is diminishing. Similarly, the gender gap for initiation to cannabis is closing (Jones 1993). My study of the ACT Drug Indicators data showed that in the older cohorts, males began using cannabis at a younger age than females, but that among those under 30 years of age, there were no significant gender differences in the age of initiation of cannabis. These results are somewhat different from population samples which have found that there is still a small gender gap in initiation to cannabis use even among the younger cohorts.

Among young illegal drug users the similarities in age for starting cannabis may be explained by the competing constructions of femininity in different social groups. Some girls in their early teens reject the constraints of the 'nice girl' stereotype and instead chose for themselves an identity that involves rebellion, fun and excitement (Banwell and Young 1993). Props for this rebellious identity are adult activities such as smoking and drinking and, for some, illegal drug use. Among contemporary illegal drug using groups, there is a culture that celebrates intoxication and fun (Dance and Mugford 1992), which frees women from the general social prohibitions on drug use. Amongst these groups, there is a different social construction of femininity which supports as normal those women who chose to use illegal drugs, get drunk and 'party' with their male contemporaries.

Initiation patterns among the men and women in the ACT Drug Indicators Project support this argument. In regard to legal drugs, in keeping with their sisters in the general community, females began using tobacco and alcohol at an older age than males. The traditional social construction of gender had shaped gender patterns of initiation among the ACT Drug Indicators women as well as women in the general community, raising the age that females compared to males first tried experimenting with alcohol and cigarettes - symbols of adulthood. Initiation for cannabis showed more complex gender patterns. Among the older cohorts, the gender patterns for the legal drugs continued - women began at an older age than males. But in the younger cohorts, those under 30 yrs of age, there was no significant difference in the age of males and females when they began using cannabis, showing the beginning of changes in the gender patterns of initiation.

Furthermore, on average, about a year after the young women started using cannabis, they began drinking regularly, but at a *younger* age than their males counterparts. In addition, for the other illegal drugs, women began using at either the same or a *younger* age than males. This part reversal in the gender patterns of initiation, I have argued, is a reflection of the gender norms among illegal drug using groups which support and celebrate intoxication among both men and women. Whereas beginning legal drug use was partly shaped by the traditional construction of femininity, the picture is different for young women who chose to experiment with a more exciting and adventurous social identity and are supported by social values about intoxication among illegal drug users. These values inform young women's drug attitudes and behaviours and provide social support in constructing a different social identity that resists the previous generation's traditional values about femininity. But the identity that is constructed and represented among illegal drug using groups is not the only identity that a teenager may construct for herself, nor will it remain static during the woman's life.

In addition, as this study has demonstrated, competing social constructions of femininity can change behaviour over time within one country, such as occurred among the women in the ACT Drug Indicators Project who had been born in different decades. Furthermore, norms about femininity vary in cultures, such as drug using cultures and ethnic cultures. Consequently, even within one country, in different cultures, the boundaries about acceptable femininity may be different but nevertheless, there are still taken-for-granted notions of acceptable behaviour for each of the sexes. Hser's (1987) study of initiation into illegal drugs showed some differences in the beginning patterns of drug use between the white and the latino women, suggesting specific forms of

femininity in the two groups which could explain the differences in beginning drug use in the two groups of women.

## SEXUAL IDENTITY AND DRUG USE

Sexual identity is also part of the social construction of femininity. For many of the young women I interviewed, their drug using lifestyle was entwined with their efforts to grapple with a adult sexual identity. In reflecting on their drug use as teenagers, some of the women in their twenties, suggested that they may have participated in the 'drinking and drugging' lifestyle, the 'partying' of the illegal drug using groups because of their lack of confidence in themselves as a sexually desirable woman. By playing the party girl, by getting high on alcohol and other drugs, they were able to act out the role of an attractive sexual woman.

But in playing that role, those women who lack confidence in their sexuality are rendered powerless to resist the male sexual drive discourse. They were often seen as sexually available, sometimes because they are intoxicated, at other times because their partying lifestyle positioned them as 'loose' women. Furthermore, their lack of sexual confidence rendered them passive and unable to assert their desires and pleasure. Women who were sexually abused as children are doubly vulnerable to acquiescing to the demands of male sexuality. This dynamic establishes a vicious cycle in which women who are uncertain about themselves sexually are liable to submit to unwanted sexual behaviour from men which thus confirms their lack of confidence. It is not until they are able to get in touch with their feelings, voice their desires and learn other discourses about female sexuality that they were able to develop some bargaining power in their sexual relationships in regard to their sexual desires. A few women in the study had not reached that stage of confidence and were still vulnerable to sexual exploitation.

Other women (nearly twenty per cent of those interviewed) had never been pushed into unwanted sex. These women had been reasonably confident in their sexuality from their early teens, and consequently they were able to assert their sexual desires, and, as part of a benevolent cycle, their confidence prompted them to mix with men who respected their wishes which, in turn, reinforced their self-assurance. They used illegal drugs without problems and, for them, a pleasure discourse about sex and drugs was relevant to their experience.

But for the other 80 per cent, their experience with sex and drugs was more mixed, entailing both pain and pleasure. Some women who had been sexually abused as children tolerated abusive adult relationships and used drugs to mask the pain in their lives. Addressing sexual abuse in their childhood was, for some women, a necessary part in their recovery from chemical dependency. Also important in their recovery was the opportunity to construct a new identity free of the blemish and shame of their past sexual experiences. Many had been silenced by the implicit shame they felt as objects of sexual abuse. In part, they were silenced because they had accepted the social construction of femininity in which females are portrayed as 'nice girls' or 'good women'; they felt that their experience of sexual abuse disqualified them from aspiring to normative femininity. Voicing their experiences, sometimes in women's groups, broke the silence of their secret shame and provided alternative discourses about femininity and sexuality which freed them to construct new identities in which sexual

abuse was no longer their fault and so no longer needed to be a secret in their lives. Discarding the 'spoiled identity' of the victim, they were able to develop more positive concepts of self.

Similarly, there were some women who had been sexually abused, raped or even 'just' subject to coercive sex as teenagers but who had not been dependent on drugs. As they matured, they learnt new discourses about female sexuality and, with growing confidence, they were able to develop more assertive sexual relations. Some of these women gave up using illegal drugs, others continued. For those who still used, drugs now constituted a simple pleasure discourse whereas in their youth, some pleasurable drug experiences had been mixed with sexual abuse and shame. That is, although the drug using continued, its meaning and context in their lives changed as they matured and developed. Most reconstituted their construction of femininity and sexuality into accounts that encompassed their drug use and their sexual experiences. These women were no longer silenced about their sexual histories, just as those in NA are no longer silenced about their drug use.

This dissertation has shown that an understanding of the constructions of gender in drug use and treatment regimes, and even in measurement and estimation of community levels of drug use, is integral to providing a more complete picture of illegal drug use.

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## APPENDIX A

### Review of the rationale and literature on multiple indicators of illegal drug use

Developing methods to monitor the levels and nature of illegal drug use has proved to be a much more difficult task than measuring the use of legal drugs such as tobacco and alcohol. Given that the use of illegal drugs may lead to prosecution, the information is sensitive and so more difficult to access. For example, one of the perennial questions asked - 'How many heroin users are there?' has been the subject of debate in many different countries and communities (Person, Retka et al. 1976; Hartnoll, Mitcheson et al. 1985; Parliamentary Joint Committee on the National Crime Authority 1989; McDonald, Stevens et al. 1993; Larson and Bammer 1996) and remains contentious.

Nevertheless, there are significant harmful effects associated with illegal drugs in terms of their health and social ramifications, and so knowledge about illegal drug use is needed for policy formulation, planning of prevention campaigns and other services, and evaluation of intervention strategies, including crime prevention. However, the task of finding adequate ways of measuring illegal drug use has not been easy. Both direct and indirect measure have been used to measure illegal drug use. Drug related deaths and drug seizures and arrests are examples of indicators that have been used as *indirect* measure of the level and nature of illegal drug use in the community. School and household surveys are a more *direct* measure of illegal drug use but some illegal drug using populations are 'diffuse and difficult to locate' (Nicholas Clarke and Associates 1987:6) and may be less likely to be included in such surveys. For example, school surveys previously have been used as a measure of teenage drug use but recently, surveys of 'street kids' have shown a much higher level of illegal drug use among that population than occurs among school students. Kosel (1986) observes of the United States household and school surveys that both data sources probably result in somewhat conservative estimates of drug use; school surveys because of the 'exclusion of dropouts and absentees' and household surveys because they 'exclude populations in institutional settings (prisons, military bases and colleges) as well as transient and nonresidential populations'. The advantage of population surveys is that they use probability samples which allow extrapolation to the general population. And, when conducted regularly, such as 2-3 yearly, with measures that are standardised and applied consistently over time, household surveys have provided a good measure of drug use *trends*, 'including both prevalence and incidence data as well as changes in attitudes and beliefs about drugs' (Kosel and Adams 1986). In general, survey data have been of 'greatest value in assessing drugs other than heroin' (Greene, Nightingale et al. 1975:403). The picture that they provide on much illegal drug use is incomplete in various ways and data from other sources is needed to complement these type of surveys.

The use of multiple data sources as drug indicators to provide a more accurate picture of the incidence, prevalence and character of illegal drug use was an approach first developed in North America and Britain over two decades ago (Greene 1974; 1985; Hartnoll, Mitcheson et al. 1985; Rootman 1988). Under this approach, if the patterns and trends revealed from different sources are consistent with each other, then

confidence that the measure as valid reflections of drug use in the community is strengthened. However, much of 'the data collected must be obtained from special populations that only imperfectly represent the drug-using populations as a whole' (Greene, Nightingale et al. 1975:402), so it is important that to be aware of the weakness and strengths of each indicator.

The development of multiple indicators of illegal drug use in the US in the early 1970s demonstrates the contribution of different indicators. Under the auspices of the National Institute of Abuse, regular household surveys (the National Household Survey on Drug Abuse) and regular school surveys (the annual High School Seniors Survey) were developed in the early 1970s which provided information on both legal and illegal drug use. The survey data, normally collected every two to three years, were supplemented by a number of other sources including the Drug Abuse Warning Network (DAWN) and the Client Oriented Data Acquisition Process (CODAP).

DAWN consisted of monthly reports from nearly 1300 sites around the country such as 'hospital emergency rooms, hospital inpatient facilities, medical examiner offices (providing forensic analysis from cases for drug-related deaths) and crisis centres' on episodes involving drugs-related problems, with the exception of those involving alcohol alone; (Greene, Nightingale et al. 1975:403). Data in the DAWN system were readily available and could provide an earlier indication of drug trends than was available by survey data.

CODAP consists of data from drug treatment agencies and has 'been used to identify relative changes in incidence through calculation of year of first heroin use' (Kosel, 1986:30). Kosel observed that heroin use is a 'relatively rare event' in the general population and so 'traditional research methods such as general surveys' have limited value for estimating incidence and prevalence particularly in localised geographic regions. CODAP data analysis on the trends in drug treatment admissions around the country demonstrated that the heroin 'epidemics which occurred in the 1960s and 1970s were national in scope, whereas the epidemics of the 1980s were more localised in geographic regions' (Kosel, 1986:30).

Trends in the incidence of hepatitis B infection, because of its 'close association' with 'parental drug use' were investigated and found to be 'a valuable indicator of trends in intravenous drug use' (Greene, Nightingale et al. 1975:403).

Law enforcement data provided information on drug trends in a number of ways. Drug market data - the level of availability of a drug - was measured by the cost, purity and quality of drugs obtained by law enforcement officers, and it was reasoned, provided indicators of the trends in the incidence of illicit drugs. Incidence of the use of a drug rose when the drug became readily available and fell when it became scarce. When drugs such as heroin become scarce, the cost rises and the purity (per cent of heroin in a buy) falls and the opposite occurs when the market is flooded with the drug. Thus, cost and purity measures provided another indicator of trends in the incidence of illicit drug use. Another source for estimating the incidence of drug use was data on the drug use among arrestees in 20 cities (sometimes verified by urine testing at arrest) which was

seen as an adjunct to treatment data as it provided 'data on individuals who may not be referred into treatment' (Greene, Nightingale et al. 1975:404).

Estimates of the prevalence of heroin users were even more complex than incidence analysis. Over the years, a variety of methods have been used. Greene(1974) describes a number of methods of heroin prevalence determination for use both nationally and in local communities. The techniques include combinations of projections from heroin over-dose deaths, extrapolation from crime statistics, surveys of heroin use with estimates to the general population and estimates of the 'hidden user' population. Person, Retka and Woodward (1976), on the other hand, combined several indicators to produce a single 'Heroin Problem Index' which, they argued, provided a better, stronger and more defensible impression as to what was happening in heroin prevalence. Multiplier techniques were a common method of estimating prevalence such as the multiple-recapture method used by Woodward, Bonnett and Brecht (1985) to estimate the size of the heroin using population by extrapolating from drug treatment admission data.

Hartnoll and co-workers (1985) also applied multiplier techniques in estimating the prevalence of heroin users in two inner London boroughs using 'projections from addicts' deaths (multiplier formula)', capture-recapture extrapolations from surveys of general practitioners, and nomination techniques. There were differences in the estimates between the methods but they were of a comparable order and allowed the construction of a best estimate which indicated that the official Home Office index of notified addicts was under-reporting the prevalence of heroin users by a factor of five.

Since the development and relative success of multiple indicators as an epidemiological method of assessing illegal drug use, the method has been gradually adopted in other countries and areas; in Canada, first with the establishment of the Federal-Provincial Task Force on Heroin Epidemiology in British Columbia, in the late 1970s (Rootman 1988; Adlaf 1995), in Europe in the early 1980s (Hartnoll 1994), and in Asia in the early 1990s (Centre for Drug Research 1995).



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# Client Record Form (for new admissions)

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1st COPY  
Yellow - ACT Drug Indicators Project  
2nd COPY  
Pink - Agency Client Profile  
3rd COPY  
Blue - Activity Indicators reports, ACT Health Authority

General Note:

Please fill in or tick a box for every question

1st COPY  
Yellow - ACT Drug Indicators Project  
2nd COPY  
Pink - Agency Client Profile  
3rd COPY  
Blue - Activity Indicators Reports, ACT Health Authority

1. AGENCY CODE: 16-17	14. USUAL OCCUPATION (even if currently unemployed): 41-46
2. DATE OF ADMISSION/CONTACT: 18-21	Not applicable..... <input type="checkbox"/> 8
3. CLIENT CODE	15. SOURCE OF REFERRAL: Tick one box only 47-48
First initial of first given name <input type="text"/>	Self..... <input type="checkbox"/> 01
First 2 initials of surname <input type="text"/>	GP..... <input type="checkbox"/> 02
4. DATE OF BIRTH (e.g. 07.08.60) 22-27	Spec. Drug Agency (incl. A&DS of govt sector)..... <input type="checkbox"/> 03
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	General Hospital/Health Services..... <input type="checkbox"/> 04
d d m m y y	Corrective Services..... <input type="checkbox"/> 05
5. SEX: 28	Police..... <input type="checkbox"/> 06
Male <input type="checkbox"/> 1 Female <input type="checkbox"/> 2 Transexual <input type="checkbox"/> 3	Court..... <input type="checkbox"/> 07
6. CURRENT RESIDENTIAL TOWN/SUBURB 29-32	Family/Friend..... <input type="checkbox"/> 08
Postcode <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 8888 = Unknown	Minister of Religion..... <input type="checkbox"/> 09
1000 = No fixed address	Solicitor..... <input type="checkbox"/> 10
7. MARITAL STATUS: 33	Refuge/Shelter..... <input type="checkbox"/> 11
Never Married..... <input type="checkbox"/> 1	Other (please specify).....
Married (including de facto)..... <input type="checkbox"/> 2	16. PREVIOUS TREATMENT FOR DRUG USE: 49
Widowed..... <input type="checkbox"/> 3	Yes..... <input type="checkbox"/> 1
Divorced..... <input type="checkbox"/> 4	No..... <input type="checkbox"/> 2
Separated (not divorced)..... <input type="checkbox"/> 5	Unknown..... <input type="checkbox"/> 8
Unknown..... <input type="checkbox"/> 8	Number of Previous Treatments 50
8. NO. OF CHILDREN UNDER 18 YEARS OF AGE 34	One..... <input type="checkbox"/> 1
None..... <input type="checkbox"/> 1	Two..... <input type="checkbox"/> 2
One..... <input type="checkbox"/> 2	Three..... <input type="checkbox"/> 3
Two..... <input type="checkbox"/> 3	Four..... <input type="checkbox"/> 4
Three or more..... <input type="checkbox"/> 4	Five or more..... <input type="checkbox"/> 5
Unknown..... <input type="checkbox"/> 8	Types of Treatment (please tick more than one if appropriate) 51-53
9. NO. OF ABOVE CHILDREN LIVING WITH THE CLIENT 35	Residential Therapeutic Community..... <input type="checkbox"/>
None..... <input type="checkbox"/> 1	Residential Detoxification..... <input type="checkbox"/>
One..... <input type="checkbox"/> 2	Methadone Program..... <input type="checkbox"/>
Two..... <input type="checkbox"/> 3	Outpatient Counselling..... <input type="checkbox"/>
Three or more..... <input type="checkbox"/> 4	Other (please specify).....
Unknown..... <input type="checkbox"/> 8	17. CURRENT CHARGES 56-57
10. COUNTRY OF BIRTH 36-37	None..... <input type="checkbox"/> 0
Unknown..... <input type="checkbox"/> 88	Drug Offence..... <input type="checkbox"/> 1
11. IF BORN IN AUSTRALIA: 38	Other Offence..... <input type="checkbox"/> 2
Aboriginal..... <input type="checkbox"/> 1	Unknown..... <input type="checkbox"/> 8
Non-Aboriginal..... <input type="checkbox"/> 2	18. PRIOR CRIMINAL RECORD: 58
12. TYPE OF ACCOMMODATION: Tick one box only 39	Yes..... <input type="checkbox"/> 1
Parental Home/Flat..... <input type="checkbox"/> 1	No..... <input type="checkbox"/> 2
House/Flat..... <input type="checkbox"/> 2	Unknown..... <input type="checkbox"/> 8
Group House/Group Flat..... <input type="checkbox"/> 3	Previous Convictions (tick more than one if appropriate):
Boarding House..... <input type="checkbox"/> 4	Drug Offences(s)..... <input type="checkbox"/> 59
Refuge/Shelter..... <input type="checkbox"/> 5	Offence(s) Against the Person..... <input type="checkbox"/> 60
Other (please specify).....	(eg. homicide; assaults; sexual assaults)
Unknown..... <input type="checkbox"/> 8	Robbery and Extortion..... <input type="checkbox"/> 61
13. EMPLOYMENT STATUS: Tick one box only 40	Break and Enter; Fraud; Other Theft..... <input type="checkbox"/> 62
Home Duties..... <input type="checkbox"/> 1	Soliciting; Living on the Earnings..... <input type="checkbox"/> 63
Student..... <input type="checkbox"/> 2	of Prostitution; etc
Unemployed..... <input type="checkbox"/> 3	Property Damage (eg. arson; malicious
Pensioner (e.g. sick/supporting parent..... <input type="checkbox"/> 4	damage)..... <input type="checkbox"/> 64
benefit NOT unemployed benefit)	Offence(s) Against Good Order..... <input type="checkbox"/> 65
Employed (includes self employed)..... <input type="checkbox"/> 5	(eg. offensive behaviour; resist arrest)
Other (please specify).....	Drink Driving Offence(s)..... <input type="checkbox"/> 66
Unknown..... <input type="checkbox"/> 8	Other (please specify)..... <input type="checkbox"/> 67

19. DRUG TYPE: Tick the drug(s) used, Mode of Use and Frequency of Use as appropriate:

DRUG TYPES	MODE OF USE				FREQUENCY OF USE (OVER THE LAST MONTH)					
	Smoke (tick more than 1 box if approp.)	Inject	Oral	Nasal	4 or more days/wk	1-3 days/wk	less than 1 day/wk	Occasional very heavy use (eg binge)	Haven't used in last month	
OPIATES and synthetic opiates:	1	2	3	4	1	2	3	4	5	
Heroin <input type="checkbox"/> 1 68	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	30
Methadone <input type="checkbox"/> 2 69	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	31
Other (please specify) <input type="checkbox"/> 3 70	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	32
STIMULANTS:										
Cocaine <input type="checkbox"/> 4 71	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	33
Amphetamines (eg. Speed) <input type="checkbox"/> 5 72	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	34
Other (please specify e.g. MDMA) <input type="checkbox"/> 6 73	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	35
CANNABIS <input type="checkbox"/> 7 74	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	36
HALLUCINOGENS (e.g LSD) <input type="checkbox"/> 8 75	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	37
OVER THE COUNTER DRUGS (please specify)..... <input type="checkbox"/> 9 76	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	38
SEDATIVE/HYPNOTICS (i.e. tranquilisers)										
Benzodiazapines (e.g. Serapax, Rohypnol, Mogadon) <input type="checkbox"/> 10 77	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	39
Other tranquilisers <input type="checkbox"/> 11 78	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	40
ALCOHOL <input type="checkbox"/> 12 79	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	41
OTHER (please specify) <input type="checkbox"/> 13 80	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	42

20. Presenting or Primary Drug Problem (stated reason for presenting) 80-83

If inject: Where do you get your needles

21. HAVE YOU EVER USED:	YES	NO	AGE AT FIRST USE years	
Alcohol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	85-86
Cannabis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	87-88
LSD/other Hallucinogens	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	89-90
Amphetamines	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	91-92
Sedatives/Hypnotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	93-94
Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	95-96
Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	97-98
22. AT WHAT AGE DID YOU BEGIN TO REGULARLY USE?	NOT APPLICABLE		AGE AT FIRST REGULAR USE - years	
Alcohol	<input type="checkbox"/>		<input type="text"/>	99-100
Cannabis	<input type="checkbox"/>		<input type="text"/>	101-102
LSD/other Hallucinogens	<input type="checkbox"/>		<input type="text"/>	103-104
Amphetamines	<input type="checkbox"/>		<input type="text"/>	105-106
Sedatives/Hypnotics	<input type="checkbox"/>		<input type="text"/>	107-108
Cocaine	<input type="checkbox"/>		<input type="text"/>	109-110
Heroin	<input type="checkbox"/>		<input type="text"/>	111-112

APPENDIX B  
ACT DRUG INDICATOR FORMS

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POLICE DATA FORM

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General Note: Please fill in or tick a box for every question on both sides of the form.

1. AGENCY CODE: _____ 16-17	12. EMPLOYMENT STATUS: _____ 40												
2. DATE OF ARREST: _____ 18-21	Employed . . . Yes [ ] 5 No [ ] 7												
3. SURNAME: (1st two letters only) _____	Usual Occupation (even if currently unemployed): _____												
4. GIVEN NAME: (initial only) _____	Unknown . . . . . [ ] 988888												
5. DATE OF BIRTH: (eg. 07.08.60) _____ 22-27													
<table><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr><tr><td>a</td><td>d</td><td>m</td><td>m</td><td>y</td><td>y</td></tr></table>							a	d	m	m	y	y	
a	d	m	m	y	y								
6. SEX: _____ 28	13. PRIOR CRIMINAL RECORD: _____ 53												
Male [ ] 1 Female [ ] 2 Transsexual [ ] 3	Yes . . . . . [ ] 1												
	No . . . . . [ ] 2												
	Unknown . . . . . [ ] 8												
7. CURRENT RESIDENTIAL TOWN/SUBURB: _____	Previous Convictions (tick more than one if appropriate):												
Postcode <table><tr><td></td><td></td><td></td><td></td></tr></table> 8888 = Unknown 1000 = No fixed address 29-32					Drug Offence(s) . . . . . [ ] 59								
8. MARITAL STATUS: _____ 33	Offence(s) Against the Person (eg. homicide; assaults; sexual assaults) [ ] 60												
Never Married . . . . . [ ] 1	Robbery and Extortion . . . . . [ ] 61												
Married (including de facto) . . . . . [ ] 2	Break and Enter; Fraud; Other Theft . . . [ ] 62												
Widowed . . . . . [ ] 3	Soliciting; Living on the Earnings of Prostitution; etc . . . . . [ ] 63												
Divorced . . . . . [ ] 4	Property Damage (eg. arson; malicious damage) . . . . . [ ] 64												
Separated (not divorced) . . . . . [ ] 5	Offence(s) Against Good Order (eg. offensive behaviour; resist arrest) [ ] 65												
Unknown . . . . . [ ] 8	Drink Driving Offence(s) . . . . . [ ] 66												
9. COUNTRY OF BIRTH: _____ 36-37	Other (please specify) _____ 67												
Unknown . . . . . [ ] 88													
10. IF BORN IN AUSTRALIA: Aboriginal . . . . . [ ] 1 38													
Non-Aboriginal . . . . . [ ] 2													
11. TYPE OF ACCOMMODATION: _____ 39													
Parental Home . . . . . [ ] 1													
House/Flat . . . . . [ ] 2													
Group House/Group Flat . . . . . [ ] 3													
Boarding House . . . . . [ ] 4													
Refuge/Shelter . . . . . [ ] 5													
Other (please specify): _____													
Unknown . . . . . [ ] 8													

PLEASE TURN OVER PAGE

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14. CURRENT CHARGES

(A) DRUG OFFENCE(S)

Type of Offence(s) (Tick more than one if appropriate)	Drug Involved (Specify)	Section Under Which Charged (Specify)
Use; administer	[ ] 43	
Simple possession	[ ] 47	
Possess for supply; supply traffic; sell	[ ] 51	
Manufacture; grow	[ ] 55	
Other (eg. false prescription; possess equipment for administration)	[ ] 59	

(B) WHO WAS THE ARREST MADE BY:

Drug Squad [ ] 1                      Other [ ] 2                      63

(C) DRUGS SEIZED

Yes [ ] 1    No [ ] 2                      64

Type of Drug (Tick more than one if appropriate)	Amount Seized
Cannabis:	
Plant form/leaf/seeds	[ ] 65
Oil/Resin	[ ] 66
Tops dried/Sticks/Joints	[ ] 67
Amphetamine	[ ] 68
Heroin	[ ] 69
Cocaine	[ ] 70
Other (Please specify)	[ ] 71

(D) OTHER CURRENT OFFENCE(S)

Yes [ ] 1    No [ ] 2                      57

Type of Offence (Tick more than one if appropriate)	
Offence(s) Against the Person (eg. homicide; assaults; sexual assaults)	[ ] 72
Robbery and Extortion	[ ] 73
Break and Enter; Fraud; Other Theft	[ ] 74
Soliciting; Living on the Earnings of Prostitution; etc.	[ ] 75
Property Damage (eg. arson; malicious damage)	[ ] 76
Offence(s) Against Good Order (eg. offensive behaviour; resist arrest)	[ ] 77
Drink Driving Offence(s)	[ ] 78
Other (please specify)	[ ] 79

## APPENDIX C:

### INTERVIEW GUIDE

INTERVIEW GUIDE: (DRAFT MAY 1992)  
(prepared by Adele Stevens)

Date of interview:

Interview Number:

#### 1. SOCIO - DEMOGRAPHIC CHARACTERISTICS

1.1. How old are you?  
(age in years)

1.2. Where were you born?

#### **If born in Australia**

1.3. Are you of Aboriginal or Torres Strait Islander origin?

1. Aboriginal/Torres Strait Islander
2. Non-Aboriginal

1.4. What was the main language spoken at home when you were growing up?

1. English
2. Other (specify)

(If not English) - In your present home, do you speak a language other than English?  
(specify)<sup>1</sup>

#### Education

1.5. How old were you when you first left school?

1.6. Highest level of education completed:

1. Tertiary (e.g. Bachelor or higher degree)
2. Certificate or diploma (e.g. Nursing - describe)
3. Trade (e.g. apprenticeship)
4. Uncompleted tertiary
5. Completed Secondary school (e.g. Higher school certificate)
6. School certificate
7. Part secondary school (no certificate)
8. Primary school
9. Other (specify) (e.g. still at school)

---

<sup>1</sup> This question corresponds to a similar question (No. 18) in the 1991 ABS Census.



**Employment status****1.7. Do you work? At what?**

1. Home duties
2. Student
3. Unemployed
4. Pension (supporting parent, sickness)
5. Employed full-time
6. Employed part-time
7. Self Employed
8. Other (specify) (e.g. workers compensation)

**1.8. Have you been unemployed in the last 6 months?**(OTI<sup>2</sup> p12, Q2)

1. No
2. Some of the time
3. Half of the time
4. Most of the time
5. All of the time

**1.9. If employed, current occupation:****1.10. How many different full-time jobs have you had in the last 6 months (OTI p12, Q3)**

1. One
2. Two
3. Three
4. Four or more
5. None

**1.11. Usual occupation:**

Income (gross per annum):

1. \$ 0 - 4,999
2. \$ 5,000 - 9,999
3. \$10,000 - 14,999
4. \$15,000 - 19,999
5. \$20,000 - 24,999
6. \$25,000 - 29,999
7. \$30,000 - 34,999
8. \$35,000 - 44,999
9. Over \$45,000

---

2 OTI is an abbreviation for the Opiate Treatment Index devised by Darke et al. from the National Drug and Alcohol Research Centre.

**Relationships and Current Living Situation**

12. Are you presently in a relationship?

If yes, what type of relationship?

1. Girlfriend
2. Boyfriend
3. Female partner
4. Male partner

How long have you been in this relationship?

1..... months

2..... years

13. Have you ever been married?

1. Never married
2. Married
3. Living together or de facto
4. Separated
5. Divorced
6. Widowed

14. Where do you live?

1. Parental home
2. House/flat
3. Group house/flat
4. Low cost accommodation housing (e.g. Haveloch House)
5. Temporary Institution (e.g. drug treatment rehab, half way house, refuge, shelter)
6. Itinerant/temporary (eg. sleep in a car, with friends, relatives)(describe)
7. Other (describe)

15. Do you have:

Children	Yes	No
Stepchildren	Yes	No

(If applicable)

16. How old are your children?

1. Sex                      Age
2. Sex                      Age
3. Sex                      Age

17. Are all your children living with you?  
If not, describe (qualitative data)

Possible alternatives:

other parent  
grandparent(s)  
other relatives (describe)  
institution or welfare (describe)

18. Have your children always lived with you?  
If not, describe (qualitative data)

19. Who do you live with?

1. With partner only
2. With partner and children
3. With children only
4. Alone
5. In a group house
6. With parents
7. Other (please specify)

**If living with with a partner**

20. How would you describe your partner's present employment status?

1. Home duties
2. Student
3. Unemployed
4. Pension (supporting parent, sickness)
5. Employed full-time
6. Employed part-time
7. Self Employed
8. Other (specify) (e.g. workers compensation)

## 2. OWN DRUG USE

Now I would like to ask you some questions about the drugs you use or have used. (see table next page)

Age at first use: tobacco (e.g. smoked first full cigarette)

Age at first use: alcohol (e.g. first whole drink - sips and tastes don't count)<sup>3</sup>

---

<sup>3</sup> These two questions have similar wording as used in the NCADA "Street Kids" survey.

Drug History

Drug	Age at 1st Use	Age at 1st Regular Use	Who introduced you (M or F)	Where did you first use	Mode of first use	If stopped, when stopped
Tobacco						
Alcohol						
Tranxs: Barbs/Benzos Legal/Illegal (describe)						
Over the Counter Drugs (describe)						
Cannabis/Hashish						
Amphetamines and Other Stimulants						
Hallucinogens (e.g. Trips, mushrooms)						
Cocaine						
Heroin						
Other Narcotics/Opiates						
Other (specify): e.g. inhalants						

During the past 12 months, which, if any of the following drugs did you use and how often did you use them?

Code	1	2	3	4	5
Drug	Daily or more	2-3 days/wk	Weekly	Monthly	Less than Monthly
Alcohol					
Tobacco					
Tranx: Barbs/Benzos Legal/Illegal (describe)					
Over the Counter Drugs (specify)					
Cannabis/Hashish					
Amphetamines and other stimulants					
Hallucinogens (LSD, trips, mushrooms)					
Cocaine					
Heroin					
Other opiates					
Other (specify)					



**3. CHANGES IN DRUG USE**

1. Does your menstrual cycle effect your drug use in any way? For example, does your drug use either increase or decrease at certain times in your cycle? (if necessary, probe e.g. when menstruating).

If yes, how?

2. Do you use a contraceptive (e.g. the pill) - describe.

3. (If has no children) Have you ever been pregnant?

(If has children or has been pregnant) Has being pregnant ever changed your drug use?

If yes, please describe beginning with the first time you were pregnant  
(see next page)





(If appropriate) Has being a parent changed your drug use?

If yes, How?

4. (a) Have you tried to limit or restrict your drug use?

1. Yes
2. No

(b) If Yes, which drugs, and why and how have you limited or stopped use of that drug?

Prompt: Tobacco  
 Alcohol  
 Sedatives/Hypnotics (PILLS)  
 Over the Counter Drugs  
 Cannabis  
 Amphetamines  
 Hallucinogens (e.g. LSD, Mushrooms)  
 Cocaine  
 Heroin  
 Other Narcotics/Opiates  
 Other (specify)

51. Have you had treatment for drug use:

1. Yes
2. No

If Yes:

Treatment	No. of Times	1-6 Days	1-4 Weeks	2-3 Months
Formal Detoxification				
Methadon Program				
Therapeutic Communities				
Out Patient Services				
Other (specify): _____				

How effective was that treatment? Describe.

### 3. SEXUAL

I would now like to turn from asking you about drugs to ask some questions about sex.

What do you understand by the term safe sex?

Have you tried to practiced safe sex?

1. Yes
2. No
3. Don't know

Who do you prefer to have sex with?

1. Men
2. Women
3. No preference

Have you any suggestions for encouraging men and women to practice safe sex more?

Have you ever felt pushed into having sex when you didn't want it?

1. Yes
2. No

If Yes, were the circumstances generally related to alcohol or other drug use at the time?

1. Yes
2. No
3. Don't know

If Yes, who was affected by alcohol or other drugs

1. You
2. Other person
3. Both

(discuss and elaborate if appropriate)

Have you ever exchanged sex for

- accommodation, ?

1. Yes (describe)
2. No

- drugs?

1. Yes (describe)
2. No

- money

1. Yes (describe)
2. No

Have you ever been sexually assaulted?

1. Yes
2. No

If Yes, who by

1. Someone known to you
2. Not known to you

Were the circumstances generally related to alcohol or other drug use at the time?

1. Yes
2. No
3. Don't know

If Yes, who was affected by alcohol or other drugs

1. You
2. Other person
3. Both

(Discuss and elaborate if appropriate)

Did you seek help and/or report the assault?

1. Yes
2. No

(discuss if appropriate)

#### 4. NOTIONS OF FEMININITY AND DRUG USE

Has anyone commented on or criticised your drug or alcohol use?

If Yes, what form did the comments take (in general)?

Do you feel society looks down more on men, or on women, or is it about equal, who are drunk or stoned (intoxicated)?

Yes

No

Unsure

**If yes, can you give any examples of anything said to you?**

Do you feel that some people disapprove more of women who have a problem with alcohol or other drugs than they do men?

Yes

No

Unsure

If yes, has anyone said anything to you?

(qualitative data)

Probe - What said? How? When?

Possible comments by

friends  
 partners  
 children  
 parents  
 medical staff (e.g. doctors, nurses)  
 drug treatment staff  
 police or other criminal justice workers  
 other (e.g. employers, Social Security staff)

Do you think a guy would get similar criticism?

(If appropriate) Have you experienced any particular criticism as a mother or when you were pregnant? For example??

Do you think your drug use is affected in any way by:

- other people's expectations of you as a woman
- your expectations of being a woman

Can you give any examples?

What kinds of behaviour are not OK for women?

What kinds of behaviour are not OK for men?

What is expected of women in Australia today?  
 (probe) ? feminine behaviour, "nice" girls.

What gives you these ideas?  
 (probe) ? media, television, family, friends.

How do you describe yourself?

What do you do about seeing yourself as.....?

**5. FAMILY BACKGROUND**

I would like to finish up by getting some information about your family background.

**Mother:**

Education:

Occupation:

Where born:

Ethnic background:

**Father:**

Education:

Occupation:

Where born:

Ethnic background:

**Number of Siblings:**

- |        |     |
|--------|-----|
| 1. Sex | Age |
| 2. Sex | Age |
| 3. Sex | Age |

**Did any of your family use drugs on a regular basis? (e.g. drink alcohol daily)**

If Yes, what type of drugs did he/she use and how often:

Code	1	2	3	4	5
Drug	Daily	Twice Weekly	Weekly	Monthly	Every 3 Months
Alcohol					
Barbiturates/Hypnotics					
Cannabis/Hashish					
Amphetamines					
LSD/Psychedelics					
Cocaine					
Heroin					
Other Narcotics/Opiates					
Other (specify): _____					

Did you ever witness (or overhear) physical violence between your parents (or family members)

1. Yes
2. No
3. Don't know

If Yes,

How often did you witness (or overhear) this violence?

1. Daily
2. Twice weekly
3. Weekly
4. Monthly
5. Yearly

Who was most violent?

1. Father
2. Mother
3. Other (specify)

Were you ever assaulted by a parent or other family member eg. hit, kicked or pushed to the point of bruising or cuts?

1. Yes
2. No

If Yes, how often were you assaulted?

1. Daily
2. Twice weekly
3. Weekly
4. Monthly
5. Yearly
6. Don't recall exactly how often

Who assaulted you most often (and with most severity)?

1. Father
2. Mother
3. Other

Was this person generally under the influence of any drug (eg. alcohol) at the time?

1. Yes
2. No
3. Don't know

Were you ever required to engage in sexual behaviour by a parent, step-parent, other relative or family friend (eg. fondling of sex organs, masturbation, intercourse)?

1. Yes
2. No

If Yes, how often did this take place?

1. Daily
2. Twice weekly
3. Weekly
4. Monthly
5. Yearly
6. Don't recall exactly how often

With whom?

1. Father
2. Mother
3. Other (specify)

Was this person generally under the influence of any drug (eg. alcohol) at the time?

1. Yes
2. No
3. Sometimes
4. Don't know

Thank you for participating in this survey. Are there any questions that you would like to ask or any comments that you would like to add?





APPENDIX D:  
THE FLYER ADVERTISING THE SURVEY



*The Australian National University*

GPO Box 4 Canberra ACT 2601 Australia  
Telephone 06-249 5111  
Telex AA62760 NATLNI  
Fax 06-249 5571

A SURVEY CONCERNING WOMEN'S EXPERIENCE OF DRUG USE

I am a Registered Nurse who is currently undertaking a PhD with the Women's Studies Program at the Australian National University on women's drug use.

As part of that research, I am interested in interviewing any women who have used or are using illegal drugs. The aim of the survey is to look at drug use from a woman's perspective. The interview will take about one to two hours. For your time and expertise, you will be paid \$40.

The interview is completely confidential and will be conducted in private. No identifying information will be collected. I do not even need to know your proper name.

For more information, please phone me at the university on 2494355 in work hours, or at home on 2886404.

With thanks in anticipation

A handwritten signature in cursive script that reads "Adele".

Adele Stevens



## APPENDIX E:

### INFORMATION SHEET

#### INFORMATION SHEET

##### A SURVEY CONCERNING WOMEN'S EXPERIENCE OF DRUG USE

This survey is being conducted by Adele Stevens as part of her research towards the fulfillment of the requirements for the degree of Doctor of Philosophy, in the Women's Studies Program at the Australian National University. The aim of the study is to describe drug use from women's perspective. I am interested in interviewing women who have used or are using illegal drugs.

The interview will cover matters such as drug use, personal and family background and relationships, possible sexual harassment and abuse and attitudes of other people to your drug use, particularly as a woman.

The interview will take 1-2 hours and can be conducted at a private office at the university or in a place of your choosing. The interview will be completely confidential and the information recorded from the interview will not identify you in any way.

Once you begin the interview, you should not feel obliged to answer all of the questions. You may withdraw from the interview at any stage if you wish, or you may choose not to answer some questions.

Tea and coffee is available so we may have a break for refreshments during the interview if you wish.

A remuneration of \$40 is available for your time and expenses.

Thank you for offering to be involved in this survey. I look forward to meeting you at ..

Adele Stevens



## APPENDIX F:

### TABLES

**Table F1: Employment Status**

	Male		Female		Total	
	No.	%	No.	%	No.	%
Employed in paid labour force	451	37.8	92	18.4	545	32.1
Not in paid labour force						
- Details not known (police data)	208	17.4	67	13.4	275	16.2
- Unemployed	380	31.7	156	31.1	536	31.6
- Pensioner (e.g. sickness, supporting parent)	124	10.4	96	19.2	220	13.0
- Student	23	1.9	36	7.2	59	3.5
- Home duties	7	0.6	53	10.6	60	3.5
- Workers compensation (long term)	2	0.2	1	0.2	3	0.2
Totals	1197	100.0	501	100.0	1698	100.0

Note: One hundred and forty nine cases were excluded from the analysis because employment status and/or gender was unknown/missing.

**Table F2: Occupation**

	Males (n=239)		Females (n=811)	
	No.	%	No.	%
Managers & Administrators	5	2.1	25	3.1
Professionals	20	8.4	27	3.3
Para-professionals	18	7.5	18	2.2
Tradespersons	17	7.1	270	33.3
Clerks	67	28.0	67	8.3
Sales/Personal service	77	32.2	52	6.4
Drivers/Plant operatives	2	0.8	56	6.9
Labourers	33	13.8	296	36.5

$\chi^2 = 271.8$ , d.f. = 7,  $p < 0.0001$ .

Note: There were 12 people (5 men and 6 women) who could not be classified in the above occupational categories. They were presently unemployed and were unskilled workers who would take any job. They had worked in a variety of jobs classified in more than one of the above occupational categories.

**Table F3:   Age Distribution**

Age Group	Male		Female		Cases	
	No.	%	No.	%	No.	%
Under 20 years	174	58.2	129	41.8	299	
20 – 24 years	380	73.4	138	26.4	518	
25 – 29 years	338	71.5	135	28.5	473	
30 – 34 years	244	78.5	67	21.5	311	
35 – 39 years	98	76.0	31	24.0	129	
40 years and over	43	62.3	26	37.7	69	
Totals	1277	70.9	522	29.1	1799	100.0

( $\chi^2 = 37.72$ , d.f. = 5,  $P < 0.001$ )

**Note:**   Forty eight cases are excluded from this analysis; two transsexual and forty six cases where sex and/or age were unknown.

**Table F4:   Current Criminal Charges,**

Age Group	Females		Males		Total	
	No.	%*	No.	%*	No.	%*
None	292	60.7	445	38.2	737	44.7
Drug charge	178	37.0	685	58.7	863	52.4
Other offence	80	16.6	327	28.0	404	24.5
No. of Persons	481		116		1657	

\*   The percentages total more than 100 because some people were facing both a drug charge and charge for another type of offence.

**Note:**   Two hundred cases were excluded from the analysis because either sex or current criminal record was unknown.

**Table F5: Recent Drug Use: Drug Type by Gender, Drug Treatment and Corrective Services Cases,<sup>+</sup>**

Drug Type		Male	Female	Total
Cannabis	(no.)	633	302	935
	(%)	80.6	73.8	78.3
Alcohol	(no.)	588	295	883
	(%)	74.9	72.1	74.0
Heroin	(no.)	416	201	617
	(%)	53.0	49.1	51.7
Amphetamines/other Stimulants	(no.)	306	167	473
	(%)	39.1	40.8	39.7
Benzodiazepines and other Tranquillisers	(no.)	256	210	466
	(%)	32.7	51.3	39.1
Cocaine	(no.)	136	68	204
	(%)	17.4	16.6	17.1
Methadone/other Opiates	(no.)	115	64	179
	(%)	14.7	15.6	15.0
Hallucinogens	(no.)	106	48	154
	(%)	13.5	11.7	12.9
Over the Counter Drugs and other Drugs**	(no.)	81	69	150
	(%)	10.3	16.8	12.6
Total Drug Reports***	No.	2637	1424	4061
Persons Reported	No.	783	409	1192

<sup>+</sup> Data supplied by CDC, DRIC, Karralika, Toora, WHOS, Mancare, Halfway houses managed by DRIC and ADFACT, Corrective Services (ACT and Queanbeyan), Queanbeyan Alcohol and Drug Service and ACT Alcohol and Drug Service.

\* Includes four cases of Ecstasy, Angel Dust, ephidrine, medislms, Polaramine, No Doze and adrenaline.

\*\* Includes inhalants such as thinners, glue and petrol, laxatives, anti-depressants and Kava .

\*\*\* Total drug reports exceed the number of persons reported because of clients reporting multiple drug use. Percentages are calculated on the number of persons reported.

Note: Seven cases were excluded from this analysis; two transsexuals and seven cases where sex was unknown.



Table F6: Mode of Use of Amphetamines

	Male		Female		Total	
	No.	%	No.	%	No.	%
Inject	204	70.3	92	59.7	296	66.7
Oral	57	19.7	49	31.6	106	23.9
Nasal	73	25.3	40	25.8	113	25.5
Smoke	19	6.6	1	0.6	20	4.5
Total Persons	290	65.3	154	34.7	444	100.0

Note: Because multiple modes of use are sometimes reported by the one client, the percentages total more than 100.

Table F7: Mode of Use of Cocaine

	Male		Female		Total	
	No.	%	No.	%	No.	%
Inject	72	61.0	24	40.7	96	54.2
Oral	2	1.7	0	0.0	2	1.1
Nasal	59	50.0	40	66.7	99	55.4
Smoke	8	6.8	1	1.7	9	5.1
Total Persons	118	66.3	60	33.7	178	100.0

Note: Because multiple modes of use are sometimes reported by the one client, the percentages total more than 100.

**Table F8: Men and Women with a Prior Criminal Record:**

(Note that the column percentages given in this Table represent the percentage of **individuals** who had prior convictions for each specific offence.)

Previous Convictions		Males	Females	Total
Drug Offence	(no.)	421	115	536
	(%)	52.3	49.8	50.9
Offence Against Person	(no.)	206	33	239
	(%)	25.1	14.4	22.7
Robbery and Extortion	(no.)	140	31	171
	(%)	17.1	13.4	16.3
Break & Enter, Fraud, Other Theft	(no.)	408	94	502
	(%)	49.7	40.7	47.6
Prostitution Offence	(no.)	31	26	57
	(%)	3.8	11.3	5.4
Property Damage	(no.)	146	20	166
	(%)	17.8	8.7	15.8
Offence Against Good Order	(no.)	225	39	264
	(%)	27.4	16.9	25.1
Drink Drive Offence`	(no.)	318	32	350
	(%)	38.7	13.8	33.3
Other*	(no.)	97	36	133
	(%)	11.8	15.6	12.6
Unknown Type	(no.)	21	3	24
	(%)	2.6	1.3	2.3
No. of individuals with a prior conviction		No.		
		821	231	1052



## APPENDIX G

### Defining beginning drug use - first and regular use

The ACT Drug Indicators Project obtained information on two aspects of beginning use of alcohol and illegal drugs: age at first use, and age at first regular use (see Appendix B for a copy of the client record form used by the drug treatment agencies in the Project). But it was unclear what level of beginning use was being described when reporting age at first use. Age of first reported use might signal a rare event and/or small use such as a sip of alcohol or it might be a larger amount such as full or half glass of alcohol. The Project did not ascertain such differences.

These questions are partially solved by the format used in the 1991 and 1993 NCADA Household Surveys where respondents were asked a number of questions about beginning use of tobacco and alcohol. For alcohol, the questions were: 'Have you ever tried alcohol? Was it a full glass of alcohol? What age were you when you had your first drink?' and for cigarettes: 'Have you ever tried tobacco/cigarettes? What age were you when you smoked your first full cigarette?'

In the field study, I was interested in finding out what the women understood as 'beginning drug use'. For example, was beginning use understood as one's first sip of alcohol or did it constitute more - a full glass as the question used in the NCADA surveys. So I began by replicating the format used in the Drug Indicators Project by asking: 'What age were you when you first tried (drug)?' and, where necessary, followed up with prompts which allowed me to replicate the detail obtained in the NCADA surveys (i.e. age at first drinking a full glass of alcohol). One aim in doing this was to understand the process of beginning to use drugs and to allow a comparison of the methods used in the Drug Indicators Project in relation to the NCADA survey.

In addition, I began in the pilot study by asking two extra questions: 'Who introduced you to this drug?' and 'Where were you when you first used it?'. From the pilot study it became apparent that there were difficulties with these questions. The former question implies little or no agency for beginning drug users, whereas agency and desire as well as availability are elements in beginning drug use. Availability is an essential component in starting to use a drug. However not everyone who is offered a drug takes up that offer as is shown in the analysis of the NCADA household survey. Less than half those offered illegal drugs agreed that they would try the drug if it was offered by a trusted friend (Swadi 1990; Jones 1993: Table 1.1).

After the pilot stage of the field study I began asking the question: 'Can you tell me about the first time you used (name of drug)?', and, if necessary, prompted with questions to provide the detail needed, such as 'where were you, who were you with and how did you get (name of drug)?' When asked the first question, most people recalled their first experience of using and told the story, including how they were introduced to the drug and in what type of setting, e.g. home, school, park, pubs, dance parties, etc. This also solved the problem of doubt about correctly remembering the age of first use as the situation provided a context for remembering. Some women could not remember

the exact occasion for some drugs but could remember who introduced them to some drugs and/or the setting. About five per cent could not remember the details of how they first used some drugs and reported their drug use to within 1 to 2 years.

Similarly, defining regular use was not simple. The most common definition of regular use is 'use of a drug at least once a week or more often' [Bailey, 1989]. There are some difficulties establishing a consistent definition for all drugs since regular smokers are sometimes defined as those who smoke at least daily. However, in the 1994 report on Statistics on Drug Abuse in Australia (Commonwealth Department of Human Services and Health 1994:89) regular smokers are defined as those who smoked at least once a week. It is useful to have a definition that is consistent across all drugs and not to make an exception for tobacco. In this thesis, regular use of any drug is taken to mean use of a drug at least once a week.

### ***Comparing methodologies***

I was interested in exploring the field study data concerning the process of beginning alcohol use in order to test if the type of question on first use in the Drug Indicators Project generated substantially different results from the more detailed questions used in NCADA household survey. I began by asking 'What age were you when you first drank alcohol?' Often, this question triggered the story of the respondents first use of the drug in question, providing the additional information sought in the NCADA survey. If necessary, I prompted with questions to replicate the national survey such as 'Was it a full glass of alcohol?'. I coded age at first use as the age when the women reported having first drunk a full glass of alcohol or the equivalent<sup>4</sup>. Most women interviewed in the field study differentiated between sips of alcohol with the family and beginning their own alcohol use separate from the family. Most of the women saw their first use of alcohol as that time when they first drank away from family influence. For example, Trixy initially reported her own first use occurring at 12 years of age when she drank away from home. When asked if her first drink at 12 years of age had been a full glass, she then commented on her beginning alcohol use in the home at an earlier age.

I would've had a full glass when I was about 6, pretty young, my parents always, you know, having a nice meal always have a glass of wine (Trixy, 26 years).

Only a few of the women had drunk a full glass of alcohol at such a young age. The majority began in their early teens with their friends. A common response was like Emily's:

That would've been 14 as well, that I first tried it....Um, that would've been the first time I can remember drinking, like with friends...(Emily, 19 yrs).

---

<sup>4</sup> There are some problems with defining a full glass of alcohol. Using standard drink equivalents provided some estimates. For example, does half an inch of port (which has a high alcohol content) in a glass of lemonade equal a light beer? Bell and Cumming (1989) faced the same problem in a study of drinking habits in Sydney's western suburbs and adopted the solution of assuming that one drink contains 8-10 grams of alcohol.

Only two respondents considered their use with the family as constituting their 'beginning to use alcohol' and these were often special occasions such as Christmas (for Janice) or other family occasions as Kyra explains:

That's a hard one, because I'd probably have a glass of wine with family, prob'ly before, I'd say 10, say around the age of 10, I would've been given a glass of wine. AND WOULD YOU HAVE DRUNK THE WHOLE GLASS? Yes, yeah....Mmm, that would've been at a (family) celebration: some funeral, or...(Kyra, 24 yrs).

The evidence from the field study suggests that when asked about age of first use of alcohol, most respondents see the question as referring to their own use away from the family. When asked for details such as the amount of alcohol (a full glass), then a few women recalled their first drink in the family which constituted a full glass and which had preceded their drinking with friends. Therefore, rather than the question used in the Drug Indicators Project which elicited information about sips of alcohol (which generally first occurs in the family home), it seems likely that most respondents were referring to their own first use away from the family (which often constitutes at least the equivalent of a full glass of alcohol). A comparison of the field study and DIP data (see Table 5.8) further supports this understanding. The women in the field study reported having their first full glass of alcohol, on average, when they were a year younger than the women in the DIP study (see Table G1). If the respondents in the Drug Indicators Project were reporting on sips of alcohol rather than a larger amount such as a full glass of alcohol, then we would expect these people to report earlier use than the field study women whereas the opposite occurred. The women in the field study starting at an earlier age may be explained partially by the fact that those women were nearly a year younger on average (mean=24.8) than the women in the DIP study (mean=25.4). However, the age difference between the two groups is quite small and may not account for the age differences in first use.

**Table G1: Age when females first had an alcohol drink (column percent)**

Age group	Field study (n=51)	DIP (n=232)
Under 10 years old	9	7
10-11 years old	10	9
12-13 years old	35	27
14-15 years old	33	29
16-17 years old	14	17
18-19 years old	0	4
20 years and older	0	7
Total	101*	100
Average age	13.0	14.2

\* Percentage greater than 100 due to rounding